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Management in Collaborative and Integrated Healthcare
Service Systems: Concept and Practice



Annexes

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Annex A

A note on healthcare Services in Scotland and the
Integration Agenda

Annex A: A Note on Healthcare Services in Scotland and the Integration Agenda

Healthcare Services in Scotland are a responsibility of the Scottish Government though delivered through the Scottish NHS. The key functions of the NHS in Scotland are overseen by the Scottish Government. Local service delivery plans set out a delivery agreement between the Scottish Government Health Department and each Scottish NHS Board and these reflect key objectives and measures set out in a multitude of national programs and targets that represent the government's health portfolios (Scottish Government, 2012). For instance, HEAT targets that set out a performance contract between the Scottish Government and NHS Boards are based on four categories: *health improvement; efficiency and governance; access to services; and treatment appropriate to individuals* (Scottish Government, 2009; 2014).

Health improvement in Scotland is focused around patient and public involvement at the heart of strategy and practise and this is evident across the strategic narrative found in policy documentation such as the 2020 Vision for Scotland's health (Scottish Government 2011; Health Improvement Scotland, 2011). To a great extent, Scotland's healthcare service is increasingly focused on co-production as a means of service improvement, suggesting increasingly user focused service delivery.

Accountability for local performance against the standard lies with the *NHS Board* itself (Staff Governance Standard 3ed, p.10). The *Staff Governance Unit* as part of the *SEHD's Workforce Directorate* will provide support and assistance to the NHS Board on issues concerning staff governance, partnership and employment practise. The *Scottish Partnership Forum (SPF)* will play a role in annual meeting with the NHS Board Partnership Forum along with the *Scottish Workforce and Staff Governance Committee (SWAG)*, which will ensure compliance with the Staff Governance Standard. Robust links are intended between NHS Board Partnership Forums, the SPF, SWAG and the Workforce Directorate in order to support and implement the Staff Governance Standard (Staff Governance Standard 3ed, p.11).

The philosophy behind integration is that service delivery requires multiple providers in different settings, which if not coordinated or based around users, will lead to delay, duplication and gaps in service delivery (Gov UK, 2014).

Therefore integration is seen as a means of providing co-ordinated user centred services (i.e. health and social care) to improves outcomes for people who use the services (Gov UK, 2014; Scottish Government, 2010). It is about organising various tasks and performances in order to provide good quality health services (WHO, 2008). Given this purpose, integration is best seen as ongoing and varied..

Integration is best seen as a continuum rather than as two extremes of integrated/not integrated (WHO, 2008 p. 1).

Integration is also seen as a means to deal with ageing populations, dramatic rise in disease and illnesses as well as the increase in population specific healthcare

service programmes and personalised care packages (Scottish Government, 2009; WHO, 2008). Particularly in the case of Britain, the ageing population factor is most relevant since one third of its population is over the age of 50.

The other prime motive for the integration of healthcare services is in its potential to respond to resource constraints and austerities faced by many economies globally and by Britain particularly. Integrated healthcare services provide cost-efficiencies since resource can be shared and duplication can be reduced (European Commission, 2013; Scottish Government 2008; WHO, 2008). Integration as an approach also enables government to achieve a reduction in the number of national public sector organisations in Scotland (Scottish Government, 2008)

Reforms in the public sector aimed at improving services over the last 20 years have received much attention given trends such as diminishing budgets, changing demographics and rising user expectations (PSRC, 2007). In this period, public services have demonstrate many different cases of successful integrated service delivery models making a strong case of integration as a means of service innovation; that is innovative ways in which management practise, governance and quality provision for users all being improved through radical change (Kinder 2013; European Commission, 2013). Some examples of this service innovation through integration can be seen in service models across Europe such as the Social Children's day care cooperatives in Sweden, co-production for elderly care in Denmark and in the context of healthcare in Britain some service models such as the South Devon and Torbay joint care service model, the 24/7 community based care model in Kent and co-located services in West Lothian (see Gov UK, 2008; European Commission, 2013). There remains strong reform for public service innovation through integration between agencies that can further innovate to develop new public service delivery models.

Political support for service integration is likely to continue for generations to come given the fact that the public sector collectively is the world's largest service provider and largest employer and because of the increasing need for user-centred services (PSRC, 2007). However, there remains the difficulty of integration having different meanings for different stakeholders. This brings some crucial arguments to the forefront in terms of what integration accounts for in practise for different service providers.

In the Scottish Government's reforms for improving healthcare service delivery, integration of health and social care leads to addressing the challenges highlighted above. An ambitious programme of reform to improve services for people who use health and social care services, integration should ensure that health and social care provision across Scotland is joined-up and seamless, especially for people with long term conditions and disabilities, many of whom are older people (Scottish Government, 2014).

For this, the Public Bodies (Joint Working) (Scotland) Act 2014 establishes the legal framework for integrating health and social care in Scotland (Scottish Government, 2014). This bill permits the integration of local authority services with health services. In practise there presently exist Community Health Partnerships (CHP's) that deliver integrated health and social care services in

Scotland and these CHP's continue to evolve towards Community Health and Social Care Partnerships (CHCP's) that will take on two possible structural formations (Scottish Government, 2014). The first option where the Health Board and Local Authority delegate the responsibility for planning and resourcing service provision to an Integration Joint Board (a body corporate model) and the second option where the Health Board or the Local Authority takes the lead responsibility for planning, resourcing and delivering integrated adult health and social care services (a lead agency/authority model) (Scottish Government, 2014; UNISON, 2014). What model current CHP's take up remains in the making for the majority of NHS Boards in Scotland that are expected to adopt a body corporate model with the exception of Highland which has already adopted the lead agency model (UNISON, 2014).

The aim of CHPs is to enable services by working collaboratively and to address issues that affect people's health and wellbeing (NHS Fife, 2012). Scotland presently constitutes 34 CHP's that are the key mechanism for providing integrated health and social care. At present there is no national model for CHP's to follow and all CHP's align responsibilities to local circumstances (Watt et al., 2010; Forbes and Evans, 2008)

It is important to note that the integration of health and social care services as a service delivery model is marred with multiple institutional logics for organisations that attempt to deliver the services (Besharov and Smith, 2013). The integration agenda with it brings conflicting perspectives, competing organisational objectives, misunderstanding and potentially multiple perceived outcomes (WHO, 2008; Besharov and Smith, 2013). Despite the governments faith in integrated care's potential to solve health challenges, their remains the difficulty of understanding and defining integration as per se in terms of what it translates to for the functioning of organisations. Does integration imply the structural merging of health and other agencies or does it mean the collaborating and co-ordinating of different agencies to deliver what users actually want? Does it mean virtual integration of teams of different organisations? Does it imply intra agency integration (i.e. primary and secondary care) or inter-agency integration (i.e. health and social care)? Related to this for instance, what does this mean for the terms of employment for integrated staff?

The Scottish Government in its outline of the integrated health and social care agenda is not ignorant of these complexities and tensions but infact acknowledges them as part of the integration process (Scottish Government, 2009). It also attempts to define what integration means in terms of quality healthcare service (e.g. Gov UK guideline, 2014) but falls short in attempts to illustrate how integration actually occurs and how it is delivered at the local level. And, for this reason, historically the NHS has been subject to structural integration and very little about effective collaboration of services from the users perspective (Britnell, 2013). The Scottish government attempts to address these confusions through its policy and framework by explicitly defining what quality care entails, who it is for and that the agenda is joint service delivery between health and local authorities.

But what will such health and social care integration mean at the ground level and how might it be implemented is open to exploration. For service managers in

healthcare, change remains the only constant and *health and social care integration is the latest mantra for improving care* (Hopson, 2013). Integration in definition could mean whatever the government define it as; but the challenge remains in understanding and translating for the sake of practise; the actual doing of it. Potential answers lie with two critical factors. One being that service purpose; integration for that matter must be designed with the user at centre stage and as focal point. The second that the local context matters most and integrated service delivery must be designed and delivered according to local needs (Britnell, 2013; Hopson, 2013). Only when this can be kept in mind when attempting to understand and implement integration, then only can public service organisations go beyond structural integration towards service systems that are actually about integrating for the sake of patient betterment (Hopson, 2013).

Annex B

A note on Public Sector Management and the NHS

Annex B: A Note on Public Sector Management and the NHS

The public sector from the 1940's to the late 1970's saw an era where government planned the economy and ran industries in the post war period. This saw the establishing of the NHS in 1948 as part of the welfare state aimed to serve the majority working class through a universal service where all had access to the service as provided by the state free at the point of delivery and consumption. Central to this was the controlling of the NHS by central government rather than leaving it to local organisations (Flynn, 2007; Rose and Lawton, 1999). Easier said than done, this invited political argument and debate over how health services in Britain could be best run (managed) and budgeted for in terms of balancing national responsibility versus local management of health services. For example, the elected right-wing government of the 1950's opposed elements of universal benefits of tax funded welfare services and introduced prescription charges and reduced staffing levels in the NHS (Flynn, 2007). This debate between localism and nationalism as well as the scope of what the welfare state should service has prevailed ever since in the interest of better health provision (Flynn, 2007). This dilemma of what should be controlled centrally and what locally has bestowed upon the NHS constant restructuring and reorganising since its conception. Despite pressure for administrative centralism from Westminster, NHS Scotland has maintained a separate identity and organisation since the conception of the British NHS in 1948 (Nottingham, 2000). What the NHS also inherited was the influence of the medical profession in how they service would be run (Lapsley and Schofield, 2009).

Over the course of 22 years leading upto 1974, the NHS had been a source of controversy and adjustments around the national versus local debate involving how hospitals could be integrated with community health services, planning for a comprehensive national health service, how accountability could be achieved while involving professionals in decision making and how GP's could be kept independent while nationally planning best practise (Flynn, 2007, p.31)

The mid 1970's saw challenges in funding welfare services out of taxation and despite an ideological attachment to the welfare state ideology, the Callaghan Labour government initiated public expenditure cuts in a bid to make public services effective (Rose and Lawton, 1999). In 1974, the NHS saw the introduction of hierarchical arrangements and the introduction of District Health Authorities for budgeting, planning and control purposes (Flynn, 2000). The demand for greater resources in the wake on continued public services drew attention to priority setting and more systematic policy making in response to scarce resources. The introduction of controls on public spending by the Labour government in 1975 was to set the ground for reforms that the thatcher government would introduce at the end of the decade (Flynn, 2000; Rose and Lawton, 1999).

The late 1970's saw an end to 30 years of growth and abundance culture with implications for both government policy that lay ahead and more importantly for

how management of public services was conceived and practised. As Rose and Lawton (1999, p.10) suggest:

The endless, infinite expansion of resources which led to a managers worth being measured in terms of input measures such as the size of departmental budgets or numbers of staff rather than outputs let alone outcomes was at an end. Attention turned to how managers might contribute to the task of what then was called cutback management. Over the next decade, the hoary old interview question, 'How would you spend an extra £1 million on your budget?' would become, 'How would you cut £1.5 million'.

In 1979 with the onset of the Conservative Thatcher government, public spending on welfare services such as the NHS took curbs while the privatising movement grew to encourage fragmentation, competition, and performance management (Stewart and Stoker, 1989). A succession of Conservative governments thereafter from 1979 to 1997 took on the agenda of reversing the decline in Britain's public sector performance and its perceived 'bad management' by taking successive steps to introduce more choice, markets and managerialist approaches (Housden, 2013)

It was the marketization era that led the way through the 1980's and into the 1990's which saw the NHS embrace a corporate structure with increased contracting for best value while the medical professions still remained influential giving rise to the clinician manager divide in the management and delivery of healthcare services and bringing to an end of an era of self-governance of the medical (Lapsley and Schofield, 2009). New Public Management had arrived referring to the business-orientated approach to running government and using performance orientated approaches to running public services (Hood, 1989; Toonen, 2001). For management in the public sector, this was the introduction of 'managerialism' to government and public sector organisations – a moving away from hierarchy and administration to market orientated management (Lynn, 2006). This American administrative ideology had been borrowed and introduced unquestionably in the belief that it would deliver cost-efficiency and effective management in a performance hungry regime:

The vague concept of management in the private sector has been borrowed more or less uncritically (Kooiman and Eliassen 1987b in Lynn, 2006 p.105)

As a Labour government took position in 1997, it had inherited a British public sector that had been largely privatised and a neo-liberal mind-set had penetrated public service organisations over 20 of years conservative rule. Much had changed with Labour finding on its hand an executive-managed NHS that could not be undone (Rose and Lawson, 1999). However NHS Scotland faced different dynamics at the time with increasing devolution for running its public services. I will discuss this further in the next section. Nevertheless, Labour being sensitive to the changes that had been made in previous government were

of the realisation that much of this change could not be undone and so, pressed forward keeping on board the NPM paradigm and its ways (Housden, 2013)

Taking on board the perceived merits of the NPM paradigm, the agenda hereafter of the Labour government was now to be 'the third way' (Carter and Woods, 2003): that of modernisation which constituted joined up governance and joint up planning and joined up solutions for the running of public services. This gave rise to public networking (networked forms of policy making and service delivery) which promoted a culture of complex partnerships arrangements among agencies such as local authorities, voluntary sector organisations and the NHS (Flynn, 2007; Rose and Lawson, 1999). The NHS saw increased public spending with this New Labour approach going into the new millennium which exercised control through best-value and complex public service agreements (Flynn, 2007). Housden (2013, p. 69) referring to this phase of public management notes:

Performance targets became ubiquitous. Incentives were sharpened through specific grants and pay policies. Inspection and intervention regimes were tightened. A great deal of continuity of approach was thus apparent. It was a restless and fidgety continuity certainly, with many strategies, task forces, Tsars and summits.

Given the limits of this thesis, it would be a never ending task to discuss the political reforms and changes that the British public sector has gone through and how this has affected the management of the NHS as an organisation. To summarise this large topic in the words of Rose and Lawton (1999):

If the 1960's saw the traditional authority in action, the 1970's the corporate authority and the 1980's the contract authority, the 1990's have seen the emergence of the networked authority (p. 21)

Entry into the new millennium has seen an extension of joint-up service models and inter-agency service delivery in public services (i.e. healthcare services) while taking a dive into a recession hit economy towards the end of its first decade. Increasingly, this has been the era of networks emerging and establishing themselves as a management and delivery model (Toonen, 1998; O'Toole, 1997; Woods, 2003). Added to this, the NHS and the public sector in general over the last eight years has been subject to policy-making and practise dominated by austerity measures while the focus on delivering co-produced user-focused services on a cost-efficient basis has increased.

What is important to appreciate is that despite differences in political opinion and approaches managing public services, public spending on healthcare and healthcare delivery will always remain a challenge since the overall population's life expectancy continues to increase and the need for constant medical innovation to offer treatments and care will place a burden on how much governments can keep spending on health as an exclusively universal public service. For the NHS, this implies the challenge of budget decisions regarding the allocation and distribution of resources and the prioritisation of which health services to fund (Flynn, 2007). The NHS will always remain subject to reform and restructuring and shall always attract controversy since its management

comes forth of political changes and government policies that are determined by short time spans (i.e. see Carter and Woods, 2003).

Therefore, to assess the NHS based on one particular period of change does not to justice given its interconnectedness and complexity (Lapsley, 2001). Rather, the NHS is better viewed as constantly evolving organisation with porous and unclear boundaries made up of interdependent agencies that deliver services. What lies at the heart of healthcare service delivery is that despite the complexity and change driven by political mandates and policy interventions, healthcare delivery and improvement is determined and starts at the ground level up because it requires effort and understanding of what works and doesn't in real life and with the engagement of different stakeholders (Naylor et al, 2001). Flinders (2004, p.1) reflects on this need to address the complex nature of public service design and delivery in new ways:

The structure of the British state is growing increasingly complex. This trend raises a number of questions that focus on the forces that stimulating this complexity and its implications for both society-state relationships and the design and implementation of public policy.

The NHS since its inception has undergone constant and significant change which to describe would be an exhaustive process. As this research study focuses on NHS Scotland, I therefore provide an overview on the main changes that particularly, NHSScotland has undergone over the course of the NHS's history and in particular during devolution, so that this study can acquire a background and context to help the reader understand and relate with issues discussed going forward.

One constant concern that a researcher is struck with when studying the management of healthcare services in Scotland is the question of: how distinct is NHS Scotland from NHS UK in identity and organisation? Certainly, my position is that it is a service within a service which should be distinguished as separate even if influenced by the dynamics of NHS UK (i.e. mainly NHS England).

For its early years, the NHS in Scotland in post war years maintained independence in Scottish health policy while at the same time desiring a comprehensive health service following the 1946 NHS Act for England Wales. Scottish health policy and NHS Scotland maintained a degree of independence through the creation of Scottish Hospital Management Boards which had more devolved powers in contrast to Hospital Management Committees in England and also had the participation of its historic University teaching hospitals. In Scotland, the administrative control of the NHS was placed in the hands of the Scottish Secretary (now referred to as First minister) rather than local authorities as in England (Jenkinson, 2000). Even in the early years of its inception, the NHS in Scotland maintained a separate identity from the Health Ministry in England. However, some would argue that between 1948 and 1974, the NHS in Scotland 'had the same tripartite structure as England' in terms of structuring (Woods, 2003). However, in the early 1970's concerns showed for the lack of integrated health management leading to a change of structure for NHS in Scotland leading to an organisation of Scottish healthcare into 15 geographically defined Health Boards appointed by and accountable to the Scottish Secretary.

This previous hierarchy-dominant administration of health had now entered the era of management by consensus where doing through teams became the managerial way in times of increasing financial constraints. Hence the need for greater efficiency in spending on delivering healthcare became the focus for the NHS in Scotland (Woods, 2003).

The desire for efficiency dominated health policy efforts in Scotland (much like the marketization of NHS England) into the 1980's with Scotland adopting and implementing ideas from Whitehall and adjusting them to Scottish circumstances such those on general management function proposed in the Griffiths NHS Management Inquiry at the health department in England (DHSS, 1983). With recommendations adopted from the Griffiths inquiry, NHS Scotland now needed a general management function to replace consensus management in the bid to make it more efficient. This saw the replacement of district set up Health Boards with 'Units of Management' (Woods, 2003 p.13). The market era for the NHS in Scotland was set.

Thatcher government with its heart set on developing an internal market in the NHS saw the introduction of NHS Trusts in England that would compete to win service contracts and improve quality as a result. Despite resistance towards this market shift, Scotland adopted, where by 1996 all former directly managed units of mainland Health Boards became NHS Trusts which now were able to commission services and responsibilities out to agencies (Woods, 2003). The era of networking has arrived for the NHS in Scotland.

Under Blair's new Labour that focused on delivering a devolved government to Scotland, the renewal of the NHS in with emphasis placed upon improving public health through partnership working was a major turning point for health service devolution for Scotland (Scottish Office Department of Health, 1997). In the quest to achieve better partnership work and integration, LHCC's were now encouraged bringing various agencies together for the delivery of health care and government policy sought to promote joint working. This 'third way' for Labour which resisted both the idea of the market and the return to hierarchical top down management, now emphasised on partnerships as a new way of delivering healthcare through multiple professional groups and organisations.

With a Scottish Parliament establishing in 1998, health and the NHS became a completely devolved concern for Scotland under the Scottish Executive (the name given to the Scottish Government executive post devolution). This devolution has further enabled NHSScotland to further distinguish itself on all accounts such as policy, budget, governance, management etc. As Housden (2013, p.66) notes:

The NHS in Scotland has increasingly taken a different path from its English counterpart. This divergence became more marked after devolution, but had been apparent since the advent of market-making reforms in England in the 1990s.

Entering into the new millennium, Scotland outlined its post devolution plan for the health service in Scotland through *Our National Health: A plan for action, a plan for change* (Scottish Government, 2006). With an emphasis on Public health and announcing *NHSScotland* as the name for the health service in Scotland, the

health boards and NHS Trusts were brought together as NHS Boards in order to simplify and improve the set-up. NHS Boards now had discretion over how they set up administrative and operational arrangements with Scottish Government only providing guideline. Among the guideline and framework provided by the Scottish Government, *Community Health Partnerships* (CHP's) were proposed that would evolve out of LHCC's now as divisions of NHS Boards to manage and improve health and social care services across Scotland.

Prevailing policy agenda's (i.e. the *National Framework for Service Change in NHS Scotland*) call for increased collaboration and partnership working between healthcare and social services, with emphasis on responding to local needs and encouraging co-produced services, that is the co-designing of services with their users ((Scottish Government 2005:3; Greer and Rowland, 2007). In many ways, this new beginning and opportunity was utilised to create a unique NHS Scotland with a unique ethos, purpose and functionality from what existed elsewhere in the UK. NHSScotland, looking to simplify its structure and with focus on delivering value, placed importance and faith in the role of clinical professionals and the historical influence of its medical institutions for the future determining and design of health services, while attempting to resist (but not alienate) market-driven models that dominated down south in NHS England. As Greer (2004, p.16) notes at the time of devolution and the new beginning for NHSScotland:

Scotland is enacting the single most interesting experiment in the UK since it is removing first the building blocks of the inherited NHS (trusts) and eroding the bedrock of the system (management). The logic behind this is fascinating and contains a potentially explosive lesson about what makes health services work.....how does a system strike the balance between providing and not providing a way that is just and yet falls within the constraints of available resources? Since 1983 the answer in the UK has been the imposition of professional management. Since 1989 the answer has been the introduction of market discipline...The skills of managers and the fire of competition were to produce efficient outcomes. The extent to which anything like a market appeared, or to which these dynamics worked can be discussed. But Scotland is going one better and slowly moving to a different model based on using professions rather managing professions.

NHSScotland currently undergoes further political reforms for driving joint-working and integration between health and social care with the Public Bodies (Joint Working) (Scotland) Act (2014) which legislates the integration of social care and health services into *Community Health and Social Care Partnerships* (CHCP's) as legal entities. The bill provides directives for local authorities and Health Boards to jointly prepare integration schemes for their respective localities in the belief that integration will ensure that Scottish health and social care provision becomes joined-up and seamless (Scottish Government, 2014).

To summarise below, I present a table to contrast the essential differences between NHS Scotland and NHS UK (mainly NHS England and Wales) that make it distinctly different.

	NHS Scotland	NHS England
Responsibility	Devolved completely to Scottish Parliament	Westminster
Governance	Partially Ministry of Health and partially outsourced via Commissioning Contracting	Participative and NHS Board driven
Financing	Funded by Scottish Government (via Barnett formula allocation for public funding) and accountable to Scottish Ministers	Westminster Government
Organisation / Set-up	NHS Boards – non competing 14 NHS Boards responsible for all healthcare services in respective geographical areas. Have partnerships between health and social care teams.	NHS Trusts – competing and commissioning services at local level.
Service Delivery model	Community Health and Social Care Partnerships. No commissioning of services and no independent sector treatment services.	Public Private Partnerships. Commissioning of services and independent sector service providers
Ethos	Universal service provision via publicly funded and managed organisations	Universal service provision via public and private funded and managed organisations

Source: Author

Annex C

Interview transcript Phase 2 and sample copies of
interviews conducted

THEMES FOR DISCUSSION

1. Organisations involved in the CHP/CHCP network

- a. Coordination
- b. Areas of difficulty

2. Governing the network

- a. Rules and procedures for operations
- b. Reporting by CHP/CHCP managers
- c. Challenges and difficulties

3. Disagreements/conflicts

- a. Resolving issues/disputes / Escalation
- b. Trust / Coalition / Cooperation

4. Individual and Group Performance

- a. Assigning management tasks as part of the partnership.
- b. Determining individual manager performance in the partnership
- c. Assessing individual performance/contributions
- d. Assessing performance as a team/group

5. Accountability

- a. The Manager as part of an inter-agency network of managers
- b. The Organisation as part of an inter-agency partnership

6. Being co-located with others as part of the CHP/CHCP

- a. Challenges and difficulties
- b. Opportunities and Positives
- c. Shared / New learning

7. 'Innovation' in Service / 'Innovation' as Teams (in Partnership working and Service Integration)

- a. Structure/Restructure
- b. Experimenting/Piloting new practices
- c. Developing multifunctional / cross network teams

8. Managers in Collaborative Partnership Work and Service Integration

- a. What skills and competences have you improved on
- b. Has past T&D prepared your skills/competences for collaborative working?
- c. What the future integrated NHS needs
- d. Future Managers – Future Teams? Skills and Competences
- e. Singular / Multiple leadership forms

THANK YOU!

Cognitive Interview used for Phase 2

1. What organisations are involved in the CHP network for delivering integrated health services

- a. Means of coordinating among each other as members of the group
- b. Areas of difficulty in the network

2. Governing the network

- a. Who sets the rules and procedures for operations
- b. Who are the different CHP managers from different agencies reporting to
- c. What are the challenges and difficulties here?

3. In the case of disagreements/conflicts arising

- a. How does the partnership resolve issues
- b. What parameters/mechanisms are in place to resolve issues
- c. Establishing and maintaining Trust / Coalition / Cooperation

4. In evaluating individual performance outcomes and group outcomes

- a. What is the system for assigning individual management tasks as part of the partnership.
- b. How do you determine performance parameter for individual managers in the partnership
- c. Who assesses your individual performance and contributions
- d. In the partnership, how do you determine performance as a multifunctional team/group
- e. Who assesses team/group performance

5. Accountability at two levels

- a. Individual Manager accountability as part of an inter-agency network of managers

- b. Individual Organisation accountability as part of an inter-agency partnership

6. What experience have you had of being co-located with other organisations for delivering integrated services?

- a. What challenges and difficulties has there been
- b. What have been the opportunities and good things about the experience
- c. Do you feel shared learning or new learning occurs as part of it (i.e. *cues below*)
 - i. Data/Information
 - ii. Informal conversation exchanges
 - iii. who you communicate with/novel ways of communicating

7. As a team, are you 'innovative' as a result of being co-located and integrated?

- a. Structuring challenges
- b. Experimenting/Piloting new practices
- c. Effectiveness in delivering service
- d. Developing multifunctional and cross network teams
- e. Who leads? Singular or Multiple leadership forms?

8. From your experience and participation in service integration and collaborative working with other agencies/organisations:

- a. What skills and competences have you improved on
- b. What different is needed in terms of skills and competences
- c. Has past T&D prepared your skills/competences for collaborative working?
- d. Favour less siloed T&D – Future cross-functional

THANK YOU!



Doctoral Research Study, University of Edinburgh

Researcher: Ally Memon

This study is part of a PhD (Management) research degree at the University Of Edinburgh Business School. The study looks to understand and capture the experiences of managers working in collaborative partnerships (i.e. Community Health and Care Partnerships) in Scottish Healthcare Services and how we can use this to improve Management Development.

Thank you for taking part in this discussion session which is approximately 45-60 minutes in duration.

All information that you provide will be treated as confidential and your personal details and those of your organisation will be treated as anonymous. You may withdraw from the discussion at any time if you wish to do so.

The discussion will be based on themes and you are welcome to ask questions at any stage. The experiences and stories you share will be of vital importance to this study.

Kindly provide your consent for participation in this study by providing the information below.

Name: _____

Designation: _____

Signature: _____

Date: _____

Phase 2 Interview Conducted in Case B

Service Manager for – Localities Children Services

Localities children services which is my core role are universal children service that apply to all children, so an example of that would be the health visiting service for children 0 – 5, the school nursing service 5 to 19, healthcare support workers. So universal service.

Specialist children services are the children from the cohort from these services I just described who needed additional support, so if its for a mental health problem they would see a child and adolescent mental health service. If it was for a child with a disability or perhaps a autistic diagnosis is required. Then they would come to specialist children services.

So the locality are covered 10,500 0 to 5 children in the NE sector and they would be children who require support in school. And the Spec Child Services (SPS) are in the element of those who have special needs.

Locality part is a public health initiative. The nurses we employ are under the nursing NMC register as a public health qualified nurses.

Can you tell me about your role ?

I cover all of ----- Sector, so I have created with the n e sector in geographical clusters, 5 equitable teams and I have 5 team leaders. That's the locality part. The other part is 2 discrete services. On a weekly basis, I could be attending strategic meetings, redesigning something in the Case B NHS board called the healthy children's program. That is taking the work from the Scottish govt. around the GIRFEC agenda, looking at the child protection agenda, looking at the PH agenda for children, and implementing and redesigning services around that. So I could be attending those meetings. I also forgot to say at the outset that I am also the service manager for family nurse partnership which is, we have that in 4 areas in the board, and this area is one of them, Case B. So I could be attending meetings, in relation to that or redesign a service called parent and child together which was originally an integrated service and will be an integrated service in the future, but we are trying to realign it to meet the needs of more focused outcomes for children and young people . .

Is that through a review,

yes it's thru a review, so I could be doing that, on the other spectrum I have supervision meetings with my team leaders, with my other direct reports. Every direct report of mine is supervised at least once a month, so on a monthly basis atleast all of them I would meet once. I have a meeting with all the team leaders once a month in the locality services to ensure that we are upto speed with the strategic redesign and I also have an operational management group meeting for specialist children services and there's 2 separate ones , one for CAMS (child and adolescent mental health) and one of pediatrics side. I am the lead for child protection for the NE sector so I also... I have the lead responsibility to ensure that the child protection inspection action plan for the NE is achieved, and in doing that I chair a health only child protection operational group, but it has all services so adult, learning disability, mental health service in the Ne sector, so I chair that group. And as a member of that group I sit on the child protection operation group partnership which is a board wide group for partnerships. And I have colleagues in social work who is unwell at the moment so I'm chairing this social work child protection forum. So that's quite a big part of my job.

I also from a staff perspective, I take all the meetings out of this room, so that I can be seen by staff and I have a 130 staff in that locality and I have quarterly meetings with them . I actually bring them together in one venue.

You're responsible for their performance reviews?

Yes all my team leaders have lead responsibilities that we have negotiated and delegated, and each of them then has a work plan with key result areas that are linked attached to that. They all have a KSF related to their job description and their scope of practice, so around being a team leader. The work plan that they have and the lead responsibilities are strategic responsibilities so someone may have taken a lead responsibility to ensure that all of the nursing development happens in the Ne sector, so they meet and actually manage the meeting for the nursing nurses in addition to them having KSF's and being managed locally.

All boards seem to be flexible in how they operate and seem to have discretion in how they practice this.

The part that's not flexible is the EKSF PDP, we follow the statutory guidance for that, everyone has an EKSF, everyone has a PDP, its reviewed as a minimum 6 monthly. The other thing I'm describing to you is a local initiative to try and develop the team leaders, because my view would be that in the future, they would be managers of a service such as this, so.

That local initiative is called?

What we have is their lead responsibilities and their key result really areas to work plans.

And to ask you about your background, so do you come from a management background and have you had formal T&D in management, or do you come from a clinical background?

I come from a clinical background. My background is adult nursing believe it or not and I'm in children children services. I'm a registered general nurse. I am a district nurse. And I have post grad qualification. I'm a specialist practitioner in palliative care. I became a practice development nurse in about 2009, followed by a lead nurse, a senior nurse, and quite quickly I secured a service manager post in the integrated CHCP managing specialist children services and I did that until the re-organisation and the re-structure in 2011 which made it a CHP again and moved me jobs. I moved from having, and also during that time I applied for and was secured a post as an integrated service manager, so I was going to be managing social work services and health services, but at that time, the social works department and the board had started falling out and disaggregating so the posts were never activated so I continued in, so at the point of restructure, although I had this post as well. So it wasn't a promotion, it was a sideways move you know, in the reorganization. They then moved me from SPS to my main substantive post which was locality children service cause I think this saw at the time, I saw it as a bit of a backward step if I'm being honest with you, cause I was managing a multi professional team, I was managing consultants, psychotherapists, So I was managing various groups and now then I've gone back to locality children services is nursing only. But I think was part of that was to lead the redesign that's happening, you know, it's such a massive re design.

So when you had CHCP set up break down , went back to CHP structure, was there new posts being created which them didn't work out, did yourself and others come back into roles that already there in existence within a band or a scale , or did posts have to be created again specially.

I was the Ne specialist children services manager and what they were planning to do is remove those posts and have integrated children services manager which would incorporate social work and roles in health. There was an interview process and some people were successful some were not, but actually they didn't process to implement the roles because Case B health and social work fell out. So my job just continued as normal awaiting for a start date and the start date didn't happen, so when I went into the restructure I went in in my substantive post, which I always had which was SPS services manager. Went through and came out the other end as a children services managers for a different service, so the grade remained the same, it was just this bit of responsibility was different.

And an answer to your earlier question, I don't have formal management training. I've got lots of leadership and I've done the LHCC, a managers program, and I was also part of the CHCP implementation managers program as well. That was where select managers went on a development program to make sure we were strategically ready for it, so I participated in both of those.

And was that a Scotland wide program?

I couldn't say to be honest because Case B was one of the first to integrate. I would get it probably wasn't, what people were saying was in LHCC's, were saying to us ARE YOU MAD, (laughs) at the time, because people were saying integration then is a step too far, which was really interesting whereas we were saying, this is the way to go to make a difference for children, adults and for our population.

The CHCP partnership we were called in Case B.

You mentioned they sent you on a course or program,

Yea that was, it was a course that was a CHCP management course and it was for teaching managers in Case B that we were clear as we moved into the new re structure reorganization as being integrated.

And do you come across short courses that are leadership orientated.

Yes, I'm also completing at the moment my master's degree in primary care at Case B Uni. There are a lot of L programs available, we also, every time we re structure, we do our psychometric testing as well. What I would say is you probably exhaust that. I think the most important thing is that your keeping upto date and reviewing what you're doing and re assessing. I'm probably quite critical of myself in reviewing what I'm doing.

The masters program was self-initiated. You have to take the drive for it absolutely. One of the parts or modules I chose to do out of the public health course was managing health care organisations, and that was quite recently I completed that last year.

1. What organisations are involved in the CHP network for delivering integrated health services

- a. Means of coordinating among each other as members of the group**
- b. Areas of difficulty in the network**

For being integrated, our main partners are SW, Education, third sector, families themselves are key partners and sometimes they are missed, as in parents and children themselves particularly older children, they certainly have a view. Case B Life would be one; they focus on culture and sport issues.

From a wider perspective in Case B, they would be council, as in library service, are key partners we work with. And Youth justice as well. We work with the police, the authority reporters. I don't if you would get that; they would not be what I would call traditional social work, because our social worker is statute for corporate parents and children. A lot of work with social work, with police and the authority reporter, (they are the Scottish authority reporter, they are the children reporters and we work to the children's panels to ensure children are treated equally. If there's a instance around an issue with a child, it would be in police would either do it or thru child protection concerns a report would be sent to the authority reporter and they would determine if a child for example needs to come to a panel whether it's thru through youth justice, if indeed they needed child protection measures taken or if no action was taken, so they are the legal aspect around that)

Involvement of the Public?

Not for children, you tend to find the PPF's are very adult focused. They had the PPF had an event last week and it was what they might call speed dating. , I don't know how better to describe it. And I was advised not to go because they wanted to focus on adult older people. I received an invite from the chair of the PPF asking me to go to a meeting cause they were interested in looked after and accommodated children. I can talk to them about looked after and accommodated children but that's not my main area of my work you know it's a proportion. So I've agreed to do that. The other way we do it is thru our health improvement

team through the health summit for children, we have the questionnaire that goes out to children about their health in schools. One of my team leaders manages the school nurses and we have bought I pads and we are using the highland pathfinder. And it's my world triangle to seek the views of children. CAMS seek the view of children thru questionnaires etc. and as part of the child protection action plan we have to do an audit annually of all our public places about information on child protection. We use in Case B a urban fox which is a group of young people who have perhaps have been previously offended or have been involved in drugs etc. But they have re habilitated and they have been doing the audits for us, so we try to do it a bit more than just tick in a box. It's really important that. We do participate with PPF but it tends not to be a great focus.

Last time I attended a big ----- PPF event, it was, it really, people really didn't understand. It was more about older people trying to say that children were being noisy in public places or you know..... does that make sense ?

2. Governing the network

- a. Who sets the rules and procedures for operations**
- b. Who are the different CHP managers from different agencies reporting to**
- c. What are the challenges and difficulties here?**

We are a third of the Case B CHP. My responsibility is one of the sector areas. So, the main governance is thru the CHP Board, which his ~~Mark~~ is our director. She obviously directly responsible to the NHS Board.

Is the CHP Board same as the CHP Management Team ?

yes it would be. So theres a CHP. ~~Mark~~ has her central CHP Management team, which would be made up of for example the directors of each of the CHP. ~~Mark~~, ~~Mark~~ and ~~Mark~~. So that would be made up of them. And then mark would take that structure and he then has the sector governance. So theres a sector governance meeting. The ----- CHP for example development plans aims and objectives, all of the strategies, what we are doing should mirror that. So its 3 strands to achieve that whole thing.

you would be reporting to sector director ?

my direct reporting is head of service. Its ----- who is the head of health and primary care community care. But that's just a very close link. But -----, director in ~~the~~ sector is also the lead director for Case B for children srvcs. Each of the directors have got key responsibilities

in addition to there being a director. So I have a very close working relationship with him because of my job.

So there a few routes thru which you report up. Or liase with and communicate with.

All of the strategic meetings, either, in the child protection operation group he chairs, you know. So it just depends on which .. but .. we are plucked in strategically. Theres the general governance around issues and complaints that takes mngt reporting and then theres, which would cover all the health and safety aspects. Then theres people governance, then obviously the strategic governance of all the re design which is service specific.


Reporting and working with ----- was with reference to ?

Lorna is the head of health and community care, and she has 3 service managers. She is responsible for all the community services in NE sector. And her 3 service managers are myself, and 2 adult service managers. Lorna would directly report to ----- who would then report to Ann Hawkins. Does that make sense?

Im viewing that in terms of the CHP set up and who's involved. Would it be right to view it from an NHS structure as well.

Absolutely, cause from the Board ----- would and ----- and other would sit on the board. All of marks response reporting in his OPR reporting would be to the Board, and anything that he reports, we are kind of underneath making sure that we achieve. Each of us even though we are service managers we have an EKSF and a PDP like everyone else. Ive got my key result areas you know. And your online objectives. And we all have that, and we are held responsible that's our key result areas. But they have to be signed off by our head of service, Lorna in this case to make sure that we are strategically covering everything that we need to do.

Trying to see the CHP and the Board and how they fit.

I don't see them as being different. I see myself as part of the NHS , my part of Case B CHP and then you know , then obviously, what we are trying to do is ultimately is meet strategic aims of the scot govt public heath you know, all of the evidence based practise about improving services.

And the CHP, might be the terminology to frame it in one place. For all we know in 2016, 2017, the word CHP MIGHT CHANGE (RESPONDS ABSOLUTELY) and something new might come in. so yes its still the exact same thing, its that NHS service, and the way the service is

connected for example in 3 sectors. But I guess its labelled as a CHP. Would that be a way of looking at it ?

absolutely, I think its probably the structure is due to size, Case B NHS , greater Case B and clyde, is massive. And if we were in, some of the more rural areas, Case B would be a Board. So I suppose if you think about it that way. If you took us to highland or somewhere, Case B city is probably larger than highland health board. So its , so what we are doing is to help achieve all, of the areas , cause within the board you've got CHCP's and CHPS's. but all of us are to collectively meet the outcomes of the Board. Its just I think its broken down in Case B in the board in such a way is because we are actually so large. It would be very very difficult to do the governance if you just had this one board. You know its one board over arching. From me I like to see it as an umbrella. The board is the umbrella, and we are all the component parts that make it up.

3. In the case of disagreements/conflicts arising

- a. How does the partnership resolve issues**
- b. What parameters/mechanisms are in place to resolve issues**
- c. Establishing and maintaining Trust / Coalition / Cooperation**

We are a health only CHP , the example im going to give you in an integrated one. Because although we are in a health mngt structure, in children services we cant actually function with out social work colleagues because because it's a corporate pay rate time responsibility and the number of looked after and accommodated children, so if we have got a dispute for e.g. around the care of a child, what would happen is if the staff member cant resolve it, we have an escalation process, so they would take it to their team leader and supervision, if it could wait. If it cannot , if its urgent. So for example of social work weren't picking up of a child because development needs weren't enough, if it didn't meet the thresholds as such, then they would escalate that. If they couldn't resolve that, they would escalate it to me and I would take it to my service managers colleagues in social work and that would go up until we get to marks level. I must say it has never got to, it doesn't happen very often. One of the advantages of being around for a while and being in the integrated structure is that I've got a really good relationship because I use to sit around the table as peers with most of these people. Is that we tend to sort it out. Theres only been a couple of times that we've had to escalate it to head of service and its been sorted really quickly. So apart from that, their probably, I think pretty much people are on the same page you know. Theres nothing

strategically that I would say is, in my head, that great that it would need to go to any level of conflict resolution.

Any involvement of Joint assessment groups?

For children you mean?

Yes, im not aware of any such. Where I know we have joint groups would be where we have the multi-agency GIRFEC plan for children and we would be creating joint groups as part of their liaise and collaborative in the one Case B approach to that. And that would be a joint support group. And the joint support group would be about different agencies coming together because the child has a request for assistance. For eg. They need a nursery place and we cant provide that in health so they would come together and there might be some conflict resolution in there because initially they might not have a place and they might need something else. But it would be focused on children rather than just going because theres, but you would actually not be going to that cause you might think you have conflict. You might be going to that because your trying to achieve outcomes for the child thru their care plan.

4. In evaluating individual performance outcomes and group outcomes

- a. **What is the system for assigning individual management tasks as part of the partnership.**
- b. **How do you determine performance parameter for individual managers in the partnership**
- c. **Who assesses your individual performance and contributions**
- d. **In the partnership, how do you determine performance as a multifunctional team/group**
- e. **Who assesses team/group performance**

I don't know if all of Case B CHP do this, but this is how I work with my team leaders. They have the eksf which I think can be quite broad in their PDP. And therefore what I do is that each have a lead strategic responsibilities and attached to those responsibilities is a work plan which has KPI's. and that's how I measure their performance.

Group team performance – is there any assessment or evaluation of your teams work on a annual basis ?

I don't know if the assessment would probably be my KPI's. I would think. I have a EKSF PDP, but I also have online objectives which are very strategic. So a very basic example would be that we achieve the EKSF or we achieve the financial, you know, that we achieve the finance year end. But within that, theres thing that 'I will ensure that the team leaders will' or 'I will ensure that this would happen' you know. So I think that perhaps for the whole group of locality services it probably is on me.

5. Accountability at two levels

- a. Individual Manager accountability as part of an inter-agency network of managers**
- b. Individual Organisation accountability as part of an inter-agency partnership**

When you were part of an inter agency network as in a CHCP, how might one understand accountability for each partner agency in the CHCP.

In the CHCP as we were, it will have been the senior management team and the governance group. The governance group was multi-agency as was the senior mngt team meetings to the director. Underneath that service specific, my manager was a social work head of service. Children services were quite unique in that children, we couldn't have had a head of service who was health at that time, I don't know if that's changed now because of corporate responsibility for children sits with social work at that top level so, I suppose I was quite embedded in that, so I was very clear that as a health professional, for e.g. I had my NMC, I had my Health governance, I was employed by health, I had all my terms and conditions of health. But equally within the joint structure I had responsibilities as a, which were more around outcomes for children or service outcomes, the KPI's that we have just been talking about if that makes sense, because they were set up joint, so you needed to work together collaboratively to be able to achieve those. I think it was really really clear, because at the time I was in specialist children srvc's and one of the things I would say to you having come into locality services, which at the time, probably were very negative about the other staff were, about the experience they had had in that structure. And I think that some of that was about people weren't particularly clear about their role. You know, a doctor is a doctor. A psychiatrist is a psychiatrist etc. IN a public health nursing role, you, its much more universal.

And I think some of the work that we are doing there around the GIRFEC Agenda and the healthy childrens program is actually that health visitors were much clearer in their roles. So if we were to into an integrated CHCO again tomorrow it would be much clearer, where as I think with social work and health and children services the lines became a bit blurred on occasions .

And was that an area of difficulty in the network ?

Well I wasn't aware of it at the time interestingly enough because where I went ot the senior meetings, I was going as the SPS manager and I was very clear about what my service could do. But I understand from staff as I was managing them, I had quite a lot of repair work to do because we need to work with social work and education and quite a lot of people where saying 'glad to be out of that, never want to do that again'. Well I think that's a real loss. And probing them 'Why do you feel like that'. And I think its that they felt threatened, I think the differentiator of their health role was that their parameters weren't clear enough and therefore they felt that they were perhaps, or their roles were going to be consumed, they were going to be asked to do something out of their parameter of their job.

The nature of working different or more short terms long term between councils and health? was that something that came up as a thought.

No, it was something that ever came up, because my head of service was social work and she was also a lead officer in Case B, I think she probably protected her senior managers from that short termism, if that's a correct word, because we all clearly had a CHCP development plan which had long term goals and I think where it came down to differences was short terms funding. But I think in a lot of ways, if it was happening, she protected us from it. I didn't see it as a pressure at the time.

6. What experience have you had of being co-located with other organisations for delivering integrated services?

- a. What challenges and difficulties has there been
- b. What have been the opportunities and good things about the experience
- c. Do you feel shared learning or new learning occurs as part of it (i.e. *cues below*)
 - i. Data/Information
 - ii. Informal conversation exchanges

iii. who you communicate with/novel ways of communicating

yes I have had experience, not as a manager but yes as a clinician. And I also have one of my services as co located just now. The PACT service (parent and children together) is , although we are not integrated as a CHCP, we kept this service beyond CHCP's and they are an integrated service. There main IT system and function and note taking is on the social work system , not on a health system,

I think you cant underestimate how important it is , to actually have that opportunity and chance to chat and talk. When we were joint , and I suppose we weren't co-located but we were in the same building but I was with SPS and all the other managers were, so I was with my services, but I think there are great advantages to being colocated in terms of opportunity. But equally, we work just as closely when we weren't together. I think its more about the people rather than the building. See if you buy into partnership and believe in it, and people have common goals, it doesn't actually matter where they are sitting. I think if theres opportunities to..... you couldn't do that and not talk and not be together at points. We all came together at point together, but actually the partnership working in children services during in that time was really really strong. I think it was a great loss. But equally I think that the staff, for my social work colleagues, think the only thing that's different now is the governance is, you know we have different heads of service, but we still work really closely together.

Even now, if I go to a meeting and someone says, Oh is that happening in health, and I say , o yea I'll send you out something . so you know theres opportunities when your meeting someone and they say can say is this right. Or I had a admin manager because her social work manager had committed to a change with which she wasn't happy, so she phoned me and said can you confirm that's correct. And I says well I can tell you its in the papers that its been approved. That your colleagues have said this. And she said I haven't been told this. So there are always... and there I was telling her about something that had been agreed through a committee. So I think you don't need to be in a joint CHCP structure for that to happen.

7. As a team, are you 'innovative' as a result of being co-located and integrated?

- a. Structuring challenges**
- b. Experimenting/Piloting new practices**
- c. Effectiveness in delivering service**
- d. Developing multifunctional and cross network teams**
- e. Who leads? Singular or Multiple leadership forms?**

Im always trying to get people to think out of the box. I think you've covered it with the two main things of service delivery, but I think what ultimately changes service delivery is someones idea that we actually allow to in a safe practise way to try out. Because to shift service delivery is really hard because of the governance around it. And the NHS is very bureaucratic as you all know and the red tape is very difficult. So for example your not

suppose to have toys that are soft bodied because of infection control. Now I don't know how many children have died from holding a toy, so you know, and that's not a example of innovation, but as a manager I think some of my responsibility is to walk a grey line with staff, so im maintaining the governance and the overarching, but im giving them the parameter to sort of push some of the boundaries so that they can try something different. And if they did that, what we would then do is test it, see if it works, evaluate it, then roll it out, and chair it.

Its government agenda changing rather than NHS just changing for the sakes of it ?

I would agree, as a public body one of the most frustrating things, particularly in the years ive been manager, is when we come to an election or some sort of a pre election or a post election. Because the NHS is one of the things that wins votes. And by nature of that, we end of with some kind of re structure. That is not helpful because your perhaps creating some disparity, you've changed something , and then you know. So I don't know if a restructure such as that creates any innovation because I think it creates quite a lot of frustration. And sometimes fear in people because they don't want to re structure that often

At the technocratic level or governance level, is that governing constant in place and doesn't re structure as frequently. Cause theres a difference in the political agenda that might be set out every 5 years compared to the technical and or clinical people governing and running the NHS and how they decide the NHS should be run or administered.

Some of that is very much influenced by the govt. I think I mean governance as a public sector body and as responsible citizens, governance has to be in place , it's a given. We need to practise safely, we need to make sure we are offering people the best evidence, we need to deal with complaints , that's structure, if that's what you mean by the governance. Theres all sorts of different governance , and that has to be in place. And some of that through re structure doesn't shift. If govt res structured tomorrow, the board re structured tomorrow the nurses eksf and pdp, the patient she sees will still be the same.

Its more the strategic agenda that changes ?

Sometimes I think , I can recall as a clinician in the NHS, that you almost, it was peripheral, ok. If your management structure is stable immediately above you, round about you, say if the board changed or someone retired, you just notice it on a team briefing it wasn't important. Where it impacts you is when someone has tried to change you or your immediate management as a clinician becomes unstable. And I think as managers, I see one of my key roles is making sure that during all of that chaos, my service is stable. And I think that is about some of your skills about, and also being very honest because if there is something that's not within your gift to protect them, your not protecting them in a maternal way, your just trying to make sure that people come to work because as clinicians, the important thing

is delivering the care that's required or the public health agenda. Sometimes they really don't want to know, if you know, there's a financial crisis, as long as they are getting their wages and they've got their equipment for their families, so you would deal with that. But you would deal with that, but you would be open and honest and tell them that it's happening but actually, the way your behaving and the way your dealing with it isn't really impacting on them. But if you do get to a point where there's something that's going to make a service change, your going to be open and honest about it.

There is the culture of wanting to measure things (ooh yes laughs) and a culture of compliance i.e. recording/evidenced.

It's important to measure.. you measure to improve. Sometimes I think we over measure.. but the NHS has always measured. And I think we are at a point probably that we now measures everything. And I think If staff can understand the rationale for what we are measuring and what we are trying to do with it, then it's not a problem. You often don't get staff complaining about measuring something. Sometimes we measure things twice and that can be frustrating cause you have two different requests and there's something very small that's different. So you actually collating the same data because there's a measurement that is slightly different. So I think if we had robust I.T. systems to help us with some of these measurements that would help . some of the measures health staff are doing anyway, audits they are doing.. but if you can pull it through from something. We went thru a phase of that couple of years ago because we were moving to the workforce re design to healthy childrens program, we were auditing children and family's staff and they were audited out. And you needed to do it for different chunks of things where as if you could streamline some of the measures, that's the frustrating part.

For example measuring Waiting times – does it give you exceptions, does it let you make it case based or are they fixed measures.

I have RTT – I have Scottish government RTT's in CAMS. The guideline doesn't tell you how much time should be spent on a case. They child n adolescent interventions that are available for children, recommend how long a piece of work should be. But that's a guideline, but that's based on a individual child. So in Case B, we use the Choice in Partnership Approach to achieve the Scot Gov 18 week Referral to treatment – that all children should have been assessed and have their first treatment by 18 weeks, we stop counting at that point. But to achieve the Choice in Partnership Approach – which assumes children will have a certain length of intervention, because you need a flow through the service to actually get children out to get children in. And that's what can become difficult because we haven't touched on it but the NE sector of Case B city CHP the vulnerability is very high and the deprivation is very high so the children that are coming into the service for the mental health tend to be very ill

. quite often high tariff, they have actually got diagnosable mental health illnesses , so actually trying to get them out the other end is really difficult.

Once they are in the service at 18 weeks the clock stops. Scot gov target is that we will do a 1st assessment visit and see them within 18 weeks. Once they are in the service that clock stops. Its then for us to work with the clinicians, so for example if theres not enough children coming out the other end, I have to increase the capacity in the service for a short time, rather than reducing. Because this is not about reducing the quality of service to children, so that would be my role as a service manager. What I then have to justify that is to the director , to my head of service that we over spend our budget at one point in the year and call it back at another point.

If we don't achieve the RTT , it goes against our performance. An element of trust has to be there placed on service managers in trying to ensure targets will be achieved.

Coming back to innovating, how might you go about it in your work ?

I would listen, I take every opportunity when im in a meeting, I was in a meeting recently for the early years collaborative, and we were talking about meeting a stretch goal, ill give you an example, which is the 2nd strand of the early years collaborative that 85% of children will achieve their development milestones by 30 months and the clock starts ticking now, and by the end of that meeting, nursery, teachers, myself and some of my staff had an idea to actually try something new throw something different. So it doesn't interfere with normal service delivery, but it would run parallel and we're going to test it, and if it works we will roll it out. So I for me its about listening to people and giving them the opportunity to do something different.

What would rolling out mean ?

Ive already given them a verbal, and they have said it's a great idea, and im going to set up a meeting, and im hoping to do that in the next week or two. And then I'll pass it to the staff to do. And what I want to do with this one is link it into the Plan and Do See Act, the PDSA cycle of the early years collaborative is we use that as a measure so that it can fit back into the early years collaborative reporting for the Board. And then we'll measure that, and if its successful, then it could be rolled out wider.

8. From your experience and participation in service integration and collaborative working with other agencies/organisations:

a. What skills and competences have you improved on

I think I am more patient. I'm quite a completer finisher and I'm quite a driver. I think I've learnt through when I was integrated and in a service manager post is that actually, to not rush in, to be more patient, to listen and hear, not just listen. Some people just listen and do nothing about it. To actually not over commit to be actually be able to, not be frightened to say no to someone if I think that actually it's not within my remit or to actually that I can't do it at that point. I would rather do lots of things well than hundred of things badly. I think being honest is very important. These are all quite fundamental. And also treating people as a equal. Because you happen to be at some point in your life be governed by social or council rather than health doesn't mean to say we are all not trying to strive. To actually do a good job.

b. What different is needed in terms of skills and competences

c. Has past T&D prepared your skills/competences for collaborative working?

They've all contributed and helped. I think one of things that's really helpful is measurements such as psychometric testing 360 degree appraisals, so that people are actually reflecting back to you and your not just assuming.

Do you have 360's happening at present ?

I don't have a 360 but I have been involved in them and they are available. I've just had a new team leader who's just asked me for a 360, and that's thru a senior OD manager in the CHCP, so we will facilitate that so she can have that. The other thing I would say is thru your objectives and your KPI process is actually getting feedback. I also have supervision monthly from my head of service.

Do you see that as mentoring?

I would consider that part mentoring but I would be looking on that if I was not performing or functioning or not achieving something, that the supervision element would be a priority for me. I think mentoring as a by product of it.

Formal training such as clinical background and participating in the specialist practitioner qualification was part of a post grad at Case B as well, so there is always a element of leadership that comes through those.

Do you know of anything that the JIT offers on the way of T&D

you know I think they probably do, if I'm being honest in the last few years because I've been doing my masters and full time job, I haven't been jumping up to volunteer or ask. I have colleagues who

are involved in the Scot Gov leadership programs. I personally wouldn't take on anything else until I finish my masters which will be next year.

Any action learning sets in Case B managers get involved with ?

they have small leadership programs that are the 30 minute leadership programs which run at like breakfast programs. Im not involved in it. But theres a action learning leadership program just now that's preparing for the new integrated structure because the initial integrated structure is going to be adult. And ive not been asked to participate in that now , but theres certainly some action learning sets I think the the direct rand heads of children services are involved in that. That's not to say I wont be soon but im not currently at the moment. But they are always there. You don't have to look very far to find them. To be honest, I have to say that the support is there as a manager. You do get to the point where there's a element of repetition

There's no magic solution that anything needs to be different. I think if your working at a managers level and if you have an open outlook, your willing to change, willing to go into joint structures, the skills and competences you have should take you with them. The challenge is about learning a new organisation and learning the new governance structures, the parameters within it, but that not insurmountable. Its absolutely about being willing and motivated and having the vision to do it. I don't know that you need a new bag of or if there are a new bag of magic skills, because if there are, I'd like to have them now. Because your always trying to improve, your always trying to integrate. So if I think if your willing and able and you have the vision to do that, your skills and competences, and then theres learning that you would do as a new team.

Chapman & Howard Softing Context

Local CHRP level

Circle Problems How

Integration about joint partnership working and service delivery rather than structure	Barriers and Facilitators of joint working and integrated service delivery	Changing Roles and Work Processes and HRM	Changing Learning/Training/Development needs
<p>Leading across different services – Horizontal Management</p> <p>Formal and Informal Governance</p> <p>Legislation (joint working bill March 2015) and Partnership Agreements as formal governance</p> <p>Legislation and and Partnership agreements allow integrated governance</p> <p>Legality of Integration ? Bill promotes working together but does not use the term 'integration' as it is legally blurred.</p> <p>Not an integration of public bodies – but a legal framework allowing agencies to formally work together</p> <p>Governance of joint working in steps</p> <p>Stage or Level of preparation for Partnership Agreements -</p> <p>Partnership Agreements provide mechanism in place for joint working</p> <p>Creating the 'norm' through legal agreements with binding changes. (so agencies cannot withdraw from the change process)</p> <p>Emerging structures or structural change result out of / are a by-product of successful collaborative/joint working</p> <p>Such structural change creates sustainability</p>	<p>'People's' budgets as opposed to 'Aligned' budgets – budgets managed together.</p> <p>Accountability for finances different – planning and budgeting cycles.</p> <p>Journey not destination. Process not Product. Common Purpose not Multi-Purpose</p> <p>Taking away barriers for those trying to manage inter-agency (to doing)</p> <p>Trust and cooperation – the 'crux of the problem' * (implying trust and cooperation as among the elements of the problem/barrier)</p> <p>Related phenomena's using In Vivo code 'crux of the problem' (occurring regularly – being pointed out significantly):</p> <ul style="list-style-type: none"> - Different ways of operating - Agency Culture Differences – different language sets; accountabilities - Learning by doing (managing inter-agency) – learning about how management works; what/how/who accountability is to; relationships <p>Shadow Boards and Joint Officer – dealing with the 'crux of the problem' (accountability)</p> <p>Managerialism has shifted due to</p>	<p>Joint working but with different Terms and Conditions.</p> <p>Staff management issues resolved structurally through partnership agreements BUT technical employment issues not.</p> <p>Accepting this as a limitation of collaborative/joint working OR a limitation of integrated/joint service delivery</p> <p>Working and managing and operating is cross-agency inter-agency BUT Belonging remains intra-agency (within)</p> <p>Differences not realised until you start to think about how inter-agency groups and teams are managed and taken forward. (implying Learning by Doing)</p> <p>Reorganisation as an Partnership (Entity*) - Job risks at senior level and Significance locality structures.</p> <p>The innovation is in joint</p>	<p>Stages of training during career Level or Degree of Partnership or coordination between T&D providers</p> <p>Any governance for Managerial T&D formal or informal (i.e. The coordination and joint planning/delivery by T&D org's such as IHSM, JIT and NES)</p> <p>Separate training and separate T&D departments – coming up with Single Programs.</p> <p>OD functions in agencies have responsibilities outside H&SC partnerships. Being able to access the resources and bringing them together into the partnership.</p> <p>Trying to ensure that inter agency operating and intra agency belonging remains unproblematic – trying to ensure this does not create indifference because the purpose/outcome for integrated service delivery is shared/same/common.</p> <p>A leadership challenge – enabling managers to facilitate the journey and now allow structures to get in the way.</p> <p>Collaborative leadership approaches opposed to management models</p> <p>Borrow from national leadership programs for local initiatives and place managers onto national schemes.</p>

<p>Co-terminosity to Exclusive Co-terminosity</p> <p>post joint working bill and establishment of new structure (CHCP's)</p> <p>Essentially become one - part of the new partnership: a partnership agreement and a strategic plan – essentially a joint governance</p> <p>A significant change and reorganisation</p> <p>Structure will emerge with due process and senior positions will have to see where they fit (unpredictability)</p> <p>Perceptions of Change: the look of the CHP might not change or appear to change.</p> <p>Level at which the change is visible</p>	<p>devolution – management has had to become more collaborative</p> <p>General Management models do not sit – the service is driven by user focus</p> <p>Co-location a driver and facilitator – gives the partnership working and integration VISIBILITY</p> <p>The innovation is in joint planning – either strategic or operational: re-shaping service around the user;</p> <p>Maintaining professional accountabilities</p>	<p>planning – either strategic or operational</p> <p>Finding the space for innovating as local teams – as managers are too involved horizontally across programs</p> <p>Working in a collaborative and political environment</p> <p>Working beyond their own accountabilities and become influencers of change in a complex environment</p> <p>Need for common shared understanding in terms of what is expected</p> <p>Changing operations but static identities</p>
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Annex D

Interview Transcript Phase 3 and sample copies of focus
group conducted

FOCUS GROUP DISCUSSION

Case A

THE LEARNING AND DEVELOPMENT OF MANAGERS IN HEALTH SERVICES INTEGRATION

1. How can opportunities be created to support managers in their learning as they go through the changes of health and social care integration (CHCP formation) in

Possible discussion points

- ❖ Complexities of the change process
 - Resistance to complexity and uncertainty
 - Trust building
 - Agency differences (cultural/political/operational/administrative/accountability)
 - The value of 'learning by doing', 'interaction' and creating 'learning experiences'
- ❖ Convincing executives to support/fund learning
- ❖ Allowing front line/ground level managers to lead the integration as they deliver it and therefore best understand it
- ❖ Fife's 'Exclusive' terminosity and its significance for Management Development policy/governance
- ❖ Service innovation through new inter-agency processes and projects

2. What types of Training & Development initiatives can prepare and support managers to engage and lead in inter-agency networks and deliver joint services in Fife?

Possible discussion points

- ❖ Budgetary pressures and constraints finding money to deliver Management Development (MD) programs
- ❖ Job reduction and the hesitation to replace vacant posts which discourages a programmatic or systematic approach to Management Development.
- ❖ The consensus for moving from *Traditional* forms of Management Development programs to *Support* forms of Management Development programs
- ❖ Increasingly about *collaborative leadership* rather than *management models*
- ❖ Managing not only *processes and procedures* but *people and relationships*

3. Can informal learning be facilitated in some structured or planned manner at Fife CHCP? How?
4. Considering the benefits of co-location and acknowledging it as a collaboration effort, how can it be used advantageously for joint learning and training in the CHCP partnership?
5. Any suggestions for better understanding and establishing the *role, relationships* and *remit* of the collaborative manager in the Fife CHCP?



Doctoral Research Study, University of Edinburgh

Researcher: Ally Memon

This study is part of a PhD (Management) research degree at the University Of Edinburgh Business School. The study looks to understand and capture the experiences of managers working in collaborative partnerships and service integration (i.e. Community Health and Care Partnerships) in Scottish Healthcare Services.

Thank you for taking part in this discussion which is approximately 45-60 minutes in duration.

All information that you provide will be treated as confidential. You may withdraw from the discussion at any time if you wish to do so.

Kindly provide your consent for participation in this study by providing the information below.

Name: _____

Organisation: _____

Designation: _____

Signature: _____

Date: _____

Focus Group Transcript Case A

1. How can opportunities be created to support managers in their learning as they go through the changes of health and social care integration (CHCP formation) ?

D: Third largest CHCP wont it.

DC: My thoughts resonate very strongly. I suppose in terms of learning opportunities we are envisioning are around creating safe space to enable individuals for people from different parts of the system to engage into better understanding the challenges and problems and opportunities faced by colleagues operating in a different part of the system. Even if we got to a stage of a heightened level of understanding of how the changes were being perceived by SW colleagues and health colleagues and there was a kind of shared understanding, then that would be a significant way forward. There is a recognition in terms of our OD planning around supporting managers at all levels. But how to respond effectively to the changing environment it seems we have in F partnership a well-established program around collaborative leadership and that is run in conjunction with all the Case A partners and agencies and our education partners at St Andrews University. So we have access there to state of art research and thinking in terms of leadership development. But that's one program and if you think of leadership as a distributed function then anybody who is responsible for a team or achieve results through individuals is defacto a leader. We won't get everyone on that program in a year so what we are envisioning is the development of what we would call non orogrammic support arrangements which takes you into the orbit of counselling, coaching, mentoring and facilitated work groups

D: If we take the programmic approach, the shared approach, we have about 30 on a cohort. And the latest numbers for NHS Case A only in 1000 minimum people with some sort of supervisory or managerial role. And atleast another 5 to 600 minimum in social work, not forgetting housing that are part of the stakeholder community. So you're looking at a potential from first line manager to senior leaders of 1500 to 2000 people. Each at different stages of evolution in terms of integration. There's also the thing of 'understanding' integration. I think previous lived experience of attended collaborative working through joint future project and things like that was that a key barrier was not just the complexity of the change process and the uncertainty of where we are and where we are going, was the fact that we spoke different languages and that the unacceptable initial outcome of investment in development opportunities would be actually people understanding each other's roles on the basis that knowledge and understanding

breaks down the barriers and understands each other's issues. I would argue that it's only from that starting point that you can then move on to understanding the process of integration and the potential value and benefits. So I think there is potential opportunities about safe space to get people in a room. Semi structured I would guess so that it's not a typical moaning session but in a room so that they can share their own perceptions. That leads to shared understanding which in turn should lead to shared desired outcomes and then get us on that journey.

DC: I would develop on that and say there needs to be clarity around what do we mean by leadership. Therefore we look to the theory and we look at past experiences. The NHS default position of command and control is not going, and there is a general recognition, that it's not going to get us to where we need to be in terms of integration. And therefore the leadership task is more around creating a supportive and enabling environment. SO that people can make sense of integration within their localities. I think there is a growing acceptance in the Frank Strang report that was particularly important around recognising that localities are the engine room of engineering the integration. There's a sense given that outlining the scope and scale of the challenge we need to be fairly focused on priorities and where we can make a difference. And I think that is at the strategic level because they set the tone and people take their lead from people operating at that level. If they exhibit appropriate behaviours and attitudes then that's more likely to permeate the organisation. If they have a reversion to command control. Then people will be less likely to adopt the support of an enabling leadership approach that is required. So we are looking to the theory of transformational leadership and adaptive leadership and so on to guide the creation of a leadership culture that will support and enable effective integration at a locality level. And not to miss out on a key group by saying, lets focus on localities which is where front line staff make a difference and providing services to those we serve, there's the strategic bit about setting the tone and direction of travel. There is a report that came into the office that came into the office a few months ago about middle managers. And it was essentially suggesting that middle managers get this stereotypical view that they are the meat in the sandwich and they are the resistors to change because of the reasons that you outline. And the research was actually pointing out that these middle managers are actually in their specific localities often creating opportunities for people to work in innovative and new ways. So there is something about not being too pessimistic about middle managers but seeing them as the potentially the drivers of change and making the connections between the strategy and the front line. If we were prioritising we would recognise there is a lot of important work to be done around the middle managers recognising that they are a key asset.

You have an interim director in place for 18 months, I wondered what kind of joint planning was in place at that level for MD, for joint MD?

They have taken a fairly positive approach and have developed a what we would describe as a traditional project management approach, and I think there is inherent dangers in that, seeing

it as yet another project. I think integration is much more profound than that and is about culture development ultimately. And under these project management arrangements there are a number of work streams that have been identified and there is a workforce work stream. And that group is really tasked with taking a lead role and developing our leadership development approaches and our organisational development approaches going forward. Infact in Case A we were a fairly early adapter by developing our OD approach at a fairly early stage. Feb 2013. And D wrote the OD approach.

D: Its emergent

DC: And that was recognising the fundamental important of cultural developments and relationships. And fundamentally it's about people providing services to other people, so it's a very people orientated change that we are on. And there were three key components to that approach: Engagement – how do we engage the 5000 or so souls who are involved in the enterprise: Leadership development was a key component: As was workforce development. So these three aspects coalesced into our OD approach.

Was this approach or plan submitted to the board or published?

D: It was submitted to the pre-cursor of the shadow board which was the integration programme board and endorsed by them and shared with Scottish government.

DC: They kind of endorsed it and rubber stamped it without necessarily understanding what they were committing themselves to. But D and myself and other colleagues up and down the country have been making noises to the Scottish government on this very issue and saying that this is a huge change. I mean, in F we are talking about 400 million pound budget for H&SC integration. 5000 staff. This is a MAJOR exercise. And we were saying to the government colleagues "we can't really do this on our own with existing resources and we need to recognise that some level of investment needs to be made". Just the other week we got a very helpful letter from the Scottish government saying that seven million pounds had been set aside and boards were invited to make a joint submission. So we need to do the joint submission with our colleagues in social care. Looking for a share of that money and in per capita terms that works out to 0.5 million which in the grand scheme of things some people might say it isn't a great deal of money. But if you've been use to running on little budgets, it's a major resource that we can hopefully use to take forward the OD approach that we have previously articulated.

D: Currently that funding pot is 1 year only. From previous experience with Scottish government, there is every likelihood that may extend because there will always be partnerships that have slipped. However we can't plan on that basis so we are planning on a 1 year basis. It's almost a transition budget. But the good thing is it is explicitly ear marked for Organisational/Cultural development. And it makes very clear one of the elements we have to explain or expand on what we intend to do is around leadership and not as much about development.

DC: it's quite very positive and significant that its come from government because they tend to be, and have been, outcome focused in terms of H&SC integration. So we have national outcomes, local outcomes and workforce outcomes that we have to meet as a local partnership.

D: And I would say, also a focus on process. Integration process and integration in structures has normally been the government approach. So this is quite encouraging that they have realised the important of culture and people development in general.

DC: And we are not just saying that because we have banged on about that. But it's a happy coincidence (reaction: feeling of happiness)

How would performance appraisal work with joint teams? E.g. EKSF and KPI systems

DC: I would put in the context that we are in the 2nd year of a 10 year move towards the development of integrated working. The audit generals report was interesting because he was saying that he would have expected after a year to have seen things to have evolved a bit more in terms of new ways of working and new models of care. One of the things we are working through just now with our communications colleagues is around some key messages. One of the key messages emerging is this point that the employment status of staff won't change as a consequence of integration. People will continue to enjoy their current terms and conditions of employment. And for the vast majority of staff they will continue to do what they are currently doing and they will continue to report to the person they are currently reporting to. Now there I a thought that because of the financial challenge and the demographic changes in demography that such a position is sustainable and we can envision a future where there are perhaps less staff doing the same or more than we currently have. But the counsel would manage that in a very different way. They have for example voluntary service agreements where as in NHS Case A we tend to manage through natural wastage and attrition. And the cultures of the two organisations are very different. But if we start from the premise that peoples T&C's will remain the same, then the KSF is an integral part of the Agenda for Change Pay Modernisation Agreement. And therefore NHS staff will remain committed to ensuring staff have a pdp under the KSF arrangements. And the council have their performance management arrangements and it was called Contribution Management Scheme. A KPI scheme essentially. And going through the kind of traditional appraisal kind of Performance management process. So, we have no plans to change any of that. But the interesting point you raise is that will managers have in the future this group of health staff management by health managers and another group of staff managed by council managers or will we have an integrated group of staff from someone wither from council or health

D: applying two sets of rules in terms of conditions and policies because if you accept the premise as currently understood, not in 5 or 10 years' time, that staff will retain their employment positions, it could envisage quite easily as appointment of a manager whose

managing an integrated team where staff are under two T&C's. I would imagine because this is what we broadly did in the past, that a management post may be a joint post in the H&SCP, but would either be, if they came from health would retain their health requirements, so the eKSF etc. though they will be applying two appraisal processes within their team. Therefore you could envisage the scenario that we will be training new managers sitting in joint posts or managers of integrated teams in 2 appraisal processes and as such their own going up in the management hierarchy that would apply as well. So if I became a joint post for example, I would attain my health status even though I was managing an integrated team. SO D you would be managing me in terms of health requirements but I would be managing two processes. That has been one of the biggest concerns or issues at this early uncertain stage that has been flagged up. From managerial colleagues, front line professional staff by and large are professionals. They have their own quite discreet professional requirements they will continue to meet. Whereas if you see a manager as a generic function or generic role, it could sit in either. So that has been the uncertainty which has been raised. "What about me will I have to learn Case A council T&C of employment, discipline and leave if I'm a health manager". All the HR Stuff. Which I don't think we are yet in a position to answer. To take you back to the previous attempt which was less purposeful because it did not have the weight of legislation behind it. Joint Future 2001 and 2002. They talked about aligned budgets and line staff groupings. The intent even then was to move to what we are now calling an integrated organisation and integrated teams and workforce. And that founded on the intractability of core HR issues of employment status

DC: There was ultimately parked in the 'too difficult to do' box, and it remains there in the difficult to do box. In some ways I would see the commitment to people retaining their employment status and retaining their T&C's and pension arrangements. That that creates a platform of reassurance for people.

Generally there is consensus that people staying on their side of the fence and T&C remains a limitation of integration

DC: Yes, but that doesn't mean that things don't change. And at the same time of creating that platform of assurance, we need to accelerate the process of change. Hopefully people will be more likely to engage developing new and more effective ways of working if they have that re assurance that we are not going to be changing your pensions and your salaries.

D: Let me be the devil's advocate there and say that it can act as a drag and encourage inertia. "There's no change for me. I'm alright. I don't need to participate in the bigger change process. I'm alright Jack". SO there are two sides to that coin of re-assurance

DC: that's why I come back to the fundamental of seeing it as a cultural development and the need for a certain style and approach to leading. Which is around supporting, enabling and creating a environment where people can genuinely engage in shaping the future. But our experience even today in Case A and working with senior managers is that inevitably they think about structures and they inevitably think about what this means for me. Until that question

is answered it's very difficult in a practical sense for people to truly engage in the change if they don't understand what the new affirmnet is.

D: Its that uncertainly that percolates down to the middle managers in a particular because if there immediate line manager is self-focused and thinking about structures because of where they sit in it, that will undoubtedly percolate and influence how they then deal with their teams. And I don't know when you reach that point of clarity, but I think that will be until there is an acceptable level of clarity and understanding of what the shape looks like. Not necessarily structure but the shape of the organism is or is aimed to be. Until we reach that point, engagement or investing of resources time and energy in managers their development for integration is almost a bit theoretical. I can't see a requirement for almost formative development until such time the context and shape is clearer. And I don't know how long.

The joint working bill avoids the use of 'integration'?

D: The language has moved on, all the things are talking integration. Maybe it's the only thing that doesn't say integration is the bill itself.

DC: I think they government, and I don't think they conspire to be misleading but they have said that this isn't about structural change, but your paper is making the point in F we have got 3 CHP and we'll be moving to a CHCP and we will be determining by localities in Case A and that's an important part of the journey. And THAT tends to be thought of by managers who have been in the service for 10 to 20 to 30 years as structures. So you can't in effect move from 3 CHP's to a CHCP without structural change. So there is a sense that the government have been slightly disingenuous by suggesting that this isn't about structural change because it is an important part of it as well. Getting the structures right. Form following function which is a good maxim for it. But I think at senior level what we found is that the senior team are thinking about what this will mean in structural terms. The dissolution of 3 CHP's and are doubtless thinking about their roles in the future configuration. And I think that is a human characteristic.

As the interim joint director is an appointment from the council, is there any concern that an interim director appointed rom council rather than health and whether that as implications for OD budgets in health? Might that prioritise the needs of council first rather than health?

DC: (Is taken back surprised and giggles): That's a good question

D: There's a potential for OD functions to be aligned. But my understanding at the moment is that learning is a NHS corporate function that provides a service to the whole of NHS Case A. And currently it's out with the scope of being included as a function into the new integrated entity. That will be an interesting future challenge.

DC: It's a very different OD function with the council and we have to be very careful with the language. Because OD will mean some different to different people. The council have shaped their function very differently and tend to have a focus on what I would call the 'improvement sciences', so they see it in a very rationalistic sense. Whereas we have developed out OD function in Case A which is very small and comprises of 5 or 6 people. But their focus is very

much on people and culture so there's a very different approach. But that doesn't mean to say that a symbiosis of the synergies you can get from the two approaches might be highly productive in supporting the process of change. Because the improvement sciences and the people centred OD approach both have a validity and a role to play.

D: It's a very valid question that has been considered internally but I don't think it's out there in the current priority scheme. It's there and it's valid but I think it's too early. But it's particularly pertinent with its co-terminosity. Other CHCP's or health boards where they will partner with 3 or 4 will face a different challenge because they will have retained their corporate service functions within the health corporate entity. Whereas Case A the co-terminosity could lend itself to potentially a different solution with different outcomes. But there would be feasibly a coming together of OD & Learning teams from the main partners.

Commented [A11]: Demonstrates no planning for co-produced MD between agencies (Fenwick ref).

DC: Yes and that would give a sense of horizontal integration. At the same time people at Scottish Government disconnected with the people in the Scottish government to do with integration looking at vertical integration and running a shared services agenda around how do we join HR and OD services more effectively from a national or regional perspective within health. So there's no limit to the variations in structural change that could be imposed upon ourselves.

D: Going back 10 to 15 years, the Solace report, joint working in the field of learning and management development with Case A council and social work colleagues in particular. So I think we in MD, workforce dev and leadership dev in particular we have a long track record. We didn't need that forces integral integration to recognise the value and the benefit.

DC: There is an important distinction to be drawn between shared services which requires structural change and joint working which requires joint work.

D: It's founded on relationship and trust. Knowing each other's pressures, strengths, and willingness but also knowing each other's boundaries.

What types of Training & Development initiatives can prepare and support managers to work in inter-agency networks and deliver joint services in

Any intimation for T&D service providers their agenda for health and social care integration and planned to train around it.

DC: Very much so

It feels from the information they have available that their T&D focuses around leadership and management in professional and clinical care. But what are they bringing on board for the development of service managers to be able to manage in an integrated environment? Because it's hard to identify what they have going on or planned for that agenda

D: Excellent point. I would agree totally on NES side that the predominant thing we see is around clinical leadership and that unfortunately tends to be silo driven as well as a specific

clinical profession. The SSSC have recently had senior social work leadership program, again, aimed at developing professional leaders. What we are talking here is generic managers not in post because they are a social worker or a doctor but because of their competence and the role. I think the IHM have picked up on that and the majority of things they tend to be offering is about the skillsets of a leader or manager in a complex adaptive world where integration is. So if you look on their websites. Professor ~~Robert~~ group in management have been looking at generic support workers for example. But they have also been looking at 'leading in an integrated world' and I think they have broadened that and taps into the Scottish public sector leadership. I think there's a big picture of leadership as a function in its own right that's being recognised in its own rights. But within NES and SSSC there still a focus for profession specific because that's what a lot of people are..

D: I would echo all of that and build on it. SSSC have just introduced their leadership framework. And these Leadership competency frameworks show a remarkable similarity. They say all the right words but my sense of it is that the leadership develop we need to do is context dependent and therefore needs to be rooted in the real lived experience of leaders working together in the field. And I'm thinking that this why locality leadership development is so important. So, you know, SSSC, no not another competency framework but yes we've got to have one and they've just done that. NES invested a lot of time and effort into training on a multidisciplinary basis but by and large our clinical staff at senior level.

D: yes, leadership program for AHP's, leadership programs for pharmacists, clinical psychologists, put on specifically for particular professions.

What about the JIT?

DC: The JIT they are kind of all over this. For example they have recently said that the top 10 things systems should be doing to develop their capacity to support change. Don't ask me what they were. But we have been working with colleagues at JIT for example to support the development of the integrated shadow board for Case A. We have used them to learn action learning sets for the leads, the strategic leaders, in social work and health, although that has not been a great success because people haven't been participating or engaging fully in them. And I think that is a very important indicator or where we are as a system because they are not seeing this as important because people are still very much "us and them" and don't understand the bigger picture of integration, and these are the strategic players. But also they are perhaps more comfortable in being entrenched in their own world. So moving out and being outward facing and engaging with health colleagues if you're a social worker and vice versa is not seen as important as things like getting your waiting times delivered or meeting targets.

D: Also, you are engaging with people in action learning set who are your potential competitors for a position. So there is that degree of resistance perhaps to fully open up and fully engage because I could be competing with you for a particular senior role in a years' time. So how much am I going to open up and help you change and develop to get that role?

Commented [AR2]: Why AC-sets may not have worked or are feared not to work going into integration

DC: So we have been using JIT around those kind of things: developing the board and creating an action learning set for senior managers.

D: But JIT has been all over the development agenda of setting up the transition teams and shadow board. In Case A anyway, can't speak for anywhere else.

DC: In fact JIT are suggesting that the areas that have transition teams up and running are generally more further down the road of integration than areas that don't have them so they feed those kinds of pieces into the system and hearing that encourages our interim director of H&SC to form a transition team but he was also encouraged to do that by our Chair who comes from a private sector environment and has a lot of experience in managing change and managing transition.

BY transition team are you referring to? Might they be called different else where such as sub units of shadow board, workforce development teams?

DC: It could be. In the letter from the government asking us to identify our OD plan they talk about an OD/Transition plan. We call it an OD plan.

D: There's a twofold role or descriptor I guess. There's components of a transition team which is about nailing down the intricacies of the finance work stream. So in March April next year everything is in a row, we know what we are doing etc., there's the members of the transition team who are supporting models of care. A number of them will classic functionaries whereby they are the oil that make the rest of the project group function.

DC: But we do have specific change managers who report to the director of health and social care and their job is really to oil the wheels of the projects and machinery and to support the work stream groups and to chase the progress and if there are barriers they can help overcome them. That sort of mix.

D: they are really the doers in the system to support the OD & learning resources health and social care colleague staff have. I guess we have a monthly meeting.

Are they OD managers or change managers? What are their titles?

DC: The 2 people helping to oil the wheels of the machinery are called Change Managers, that's their designation but they tend to be very much in the mould of a project manager rather than an OD practitioner supporting the people and cultural shifts.

2. Can informal learning be facilitated in some structured or planned manner at CHCP? How?

D: (Laughs) That sounds Oxymoronic We have had a number of conversations regarding this over the years about the cost benefit if you like of formalised mentoring schemes or programs. So matching mentors and mentees across systems, so we have looked at that,

we have done a little bit of it and it has always been inorganic. The two areas that have been the most robust in outcomes and longevity would be the coaching sessions. I know we stumbled on the final herd of reciprocal coaching but a coaching programme for 30 to 35 within health at the moment, but you can see it exportable and expandable. One to one period of coaching for managers involved in change. So that has probably been the longest lasting non programmatic activity. The second one would probably be the action learning sets that have grown out of what was part and parcel of our formal Management Development programs. A number of them had continued organically. End of the program they chose to continue and I facilitated their first post program session and then you're on your own. But we also have a number of action learning sets spate from the programs that are health. I can only talk about health at the moment, but they in themselves the model can be and the principles can be adopted to support learning in an integrated arena.

DC: There's a tension at the moment between us and the council at the moment that we would like very much to sustain our collaborative leadership program which is across the partnership. And we believe that to be a useful part of our offering. The council are saying that yes, but its accredited yearlong or 18 month long programme. And someone needs to commit to it. And there's all sorts of academic components.

D: It's time consuming and intensive

DC: There's an advanced postgrad certificate involved and they are saying that you can only train a small number of people with that, we need to scale up. And I can understand that as well. They are arguing also for more non programmatic approaches and what we know is that they tend to be very popular. So a hard pressed manager doesn't have time to commit to a 18 month accredited educational program but may be committed to doing some short sharp bursts of coaching support. And our chief executive group in NHS Scotland found this as a really important part of their personal development for those very reasons. And therefore D is right, we do a lot of coaching of managers who are in key position leading change and providing support in that way. I would imagine we would be doing a lot of the around H7SC integration. It's very popular from the consumer perspective.

D: it's not the management or even the offering, its how we generate the need. I would see the need coming, if we are planning a number or large scale engagement exercises with managers and staff who will be to impact and influence the integration process a number that the needs for coaching or action learning or some sort of non-programmatic approach would evolve from those exercises. And that allows us to address the oxymoron of planned informal. We recognise that there's a cohort, let's say in the west of F, of 40 managers who have been through an engagement exercise and this is a common thread coming through, we can then make the offer.

DC: But there's a tension isn't there between that process of emergence and responding to that organic demand and some of our more rational managers who would say that everyone needs to go thru the same development process and get the badge.

D: In 2 or 3 months we could easily knock up an integrated MD programme. We run one in health already without the integrated bit. It focuses on the future, they run one similar in shape in social work and council. It's not beyond anyone to knock one out together. However we have discussed that over a number of years but fell foul of the fact there that we are creating an approach that tries to address needs that are really individual. At the time we looked at it because we were under pressure by particular rationalist structural leaders as it were. That's what they wanted to see because that fitted their mind-set

Thinking about graduate entry schemes that might be merged?

D: I don't think the council do. COSLAR might.

DC: we use to have a kingdom graduate scheme that D ran and we've got the national trainee scheme for NHS.

D: We had our own in Case A that was a partnership approach between health, council, police and local colleges and at one point the fire service. But it fell foul of money issues basically..... also had a Case A MBA program that was established with fire, police, LA and health through Case A College to Napier. And that ran successfully for 3 years. And I think it lives its natural life. It was aimed at service manager's stroke middle managers. If you add them altogether there have been a number of joint initiatives that have lived their life and ended either because of funding or a change of representative on the steering group.

Is there time off in a given year for development like is the case in maybe some other boards?

DC: not specifically but there's nothing stopping managers requesting time off to go away on development

DC: we've put in huge effort to developing PDP processes and have been quite fundamentalist about it that if someone needs to do something then that should be part of the PDP process.

3. How can co-location be used advantageously for joint learning and training in the CHCP partnership?

DC: I think you are onto something there and it's not something we have exploited in ----. I think there is something about relationships and intimacy it brings and therefore the closeness which is likely to give productive relationships, and its something we should be doing more of as integration moves forward.

D: It's not about co-location per se it's the value in the learning arena of people being co-located. Can think of 4 or 5 reasonably good examples whereby the co-location almost drove the L&D agenda. If we take an integrated team that we have now co located with another integrated team, one team normally their education, training and development was profession specific. SO nurse went along to nursing and OT to OT and so on. BY bringing them into one location with social work and health care workers, and put this solely down the new manager of the team, but creating a learning environment whereby all were in the same room and there

was little bits everything come at you and your beginning to pick up the pressures of each other. It would not have happened otherwise. But to be honest, it was a mix of co-location but also the insight of the new manager in recognising the value of being co-located together and using it for developing skill sets and the team.

DC: Looking at the development needs of that team going forward. They then didn't focus on the development of professional skills, they were then very focused on developing a culture a team ethos.

D: it shifted the focus on how are we collectively achieving outcomes rather than "I'm entitled to my three days and I want to do it in nursing because that's where my professional bias is". Instead it was "I need to learn about this because that's what patients are encountering

DC: People then start to understand the respect of roles and responsibilities.

D: The value is in the learning arena of being co-located.

Exclusive terminosity for CHCP, are they planning for co-located facilities?

DC: Yes, I think that is part of the agenda but I'm not well cited on it.

D: One Prime example would be St Andrews Community hospital. But I think it will be and I would hope that it will be planned, I think it would be evolving as and when opportunities arise.

4. Any suggestions for better understanding and establishing the *role, relationships and remit* of the manager in the CHCP set-up?

DC: I see it as an important leadership role and I am quite excited by it. I see it as an opportunity to break the mould of the past and the inherent limitations of our rational managerialist practices. And a recognition that they are maybe helpful in some respects but they have severe limitations. They are in some ways necessary but insufficient. Therefore there's an awaken I think of the need for leaders to transcend that narrow view of the manager to develop, as the word is, 'collaborative' management approaches that require the person to work effectively across traditional, professional and organisational boundaries, and to work with and through people and to achieve results through people. That required us to shift the paradigm away from the kind of centralised command control models of management to a more supporting and enabling style

D: I could not agree more, but playing the devil's advocate or the cynical doubter, the challenge for supporting or developing of people in the manager role is how do we provide someone with skills, behaviours and attitudes to operate the way D describes, and also to continue to try and operate that way in the face of institutional inertia and inherent cultural resistance. If there's a command control paradigm or a bureaucratic managerial structure where certain people pay rhetorical service to the need for this kind of role and that its about relationships and behaviours, but the crushing weight of tradition and history weigh heavily on someone in

that role. So I think part of the development challenge is YES you can identify using a variety of methods the people with the right approach and mind-set and attitude, you can develop them through formal and non-formal methods. But it's how do we to continue to support them so they continue to be a beacon and don't get sucked back into the traditional models of rational management. In 10 years' time we might be there where there is enough of these people.

The resilient ones?

D: Yes, that's a good way to describe them. Resilience.

DC: I think the problem we have at the moment, is to some extent that people have been successful by adopting rational managerialist approaches. So we have people at the top of our organisations who have got to the top by adopting these very approaches and generally feel they have been successful through doing that, and don't see any need to change and would like to see that approach continue and be replicated. So I suppose there's something about H7SC integration about a good revolution starting from the bottom up and kind of creating leaders at a lower level in the hierarchies that embrace those approaches. Almost thinking that people who are at the top are a lost cause.

So localised MD?

DC: Yes

D: Yes, there's the challenge in that one because if you're the shining beacon, the resilience and the crushing weight and you're running an integrated team, there is the crushing weight of two bureaucratic institutional traditions weighing on you. The one that you have come from and probably understand and are reasonably comfortable with. And the other one which is even more challenging because it's new to you and you don't know the pressure of the game.

DC: yes, and the pressure is to conform to the dominant paradigm.

(NOTES: Head of service improvement told me once that managers who can get use to and do best of reporting up the two different streams will be the one that can get past the hurdle. SO reporting up and down the 2 streams within CHCP integration and be able to develop that network as one will be the one that gets past the hurdle)

D: Yes that's set in the legislation isn't it, the reporting lines and framework.

Annex E

**Interview Transcript and Emerging Outcomes Shared with
Interviewee and copy of the interview for Phase 4**

Phase 4: Open-ended Interview Discussion with field Expert

There was always complexity to what to call it. Academic leadership or health service leadership or various other kind of prefixes if you like. And I kept struggling with well, what is the bottom line here in all of this. Part of that is what has fuelled my interest in going through where I've got to.

I've made observations, not a critique. Just things that came to me on the points that have emerged.

When I read it, I kept thinking. That's it, that's what it's about. Those are the issues that are actually there.

1. How can opportunities be created to support managers in their learning as they go through the changes of health and social care integration (CHCP formation) in [REDACTED]

The first thing that came to me, and what's important there is the forthcoming changes from legislation which is the public bodies joint working bill 2015. What struck me is the point that it encourages integration. Because if encourage is all it's going to do, will have this same dialog in 10 years' time. There is nothing in the legislation that kind of says you must or you will or this is how it will be done. It's kind of all being left to let's try and get together, let's try and work in partnership, let's do this because that's the way we want it to be. And it all becomes an aspiration and there is no real context of how that's going to be delivered. And the findings pick up on some of these points.

The bill refrains from using the word integration. Is that because that might imply of legal entities.

I think it's doing that because it's too complex to start talking integration. The findings pick this up with issues such as governance and politics. The reasons for me relate to the concern and your finding "that T&C of employment for staff, the technical issues related to it are seen as a limitation". I would go stronger than that and say it's an absolute blockage because that concern is entrenched. I remember 3 years ago, not long ago after the GD for health service in Scotland had moved on and the new guy had come in, and he was talking about 2020 vision and he was talking about integration. But would not even enter into a dialog about the fundamental issues of commonalities in pay and working conditions, commonalities between roles. And I remember working with Edinburgh council trying to create some sort of framework for a common care assistant role that was common to Social services and health services with a really exciting vision about "wouldn't it be great if you can care for your patients in the community but then if they needed hospitalisation then you were the one who came into hospital and you nursed them in hospital, and then you saw them out and discharge them so you had that total continuity of care. But few couldn't get any level playing field in terms of a common goal, common expectation. If we could it was really low scale which would have probably been ok if you were looking at straight forward care. But if it got more and more complex than those issues came in.

There was a consent for corporate governance model over lead agency model particularly for the reason of T&C of employment that were seen as not solvable.

But there's no evidence for me that that works. I suppose the parallel for me is what's been going on in England over the last 10 years. We saw NHS acute trusts and then we saw primary care trusts in England and then they merged in the way that CHP's and CHCP merge. I suppose the only thing that made that work to some extent that the staff they employed were generally on NHS T&C and there was links to

if you like GP practices, because they actually employed if you like to use that word, some of the nursing staff, the health visitors and so on that were in the practices. And that worked. But now those have been replaced by clinical commissioning groups for example which are much bigger collaborations or conglomerates of general practise within communities. And we are left with some of the points that arise here such as What does this mean for senior managers, what does it mean for their roles. Huge pay-outs people retiring people getting out people not wanting to be part of that process anymore because its something they don't want to deal with. And for me, we still come down to this bottom line that we are not dealing with those nitty gritty issues before you actually get to this kind of concept and it seems to me that we have got this brilliant idea of what the corporate body might be or what the lead agency might be but how that then functions or operates is always kind of pushed to one side. And I think there is a total lack of guidance or direction on what that might actually look like.

And I think we have seen some good examples. I remember West Lothian, in Edinburgh, we had something like 5 CHP's in total but one of them was a CHCP in West Lothian. And it was a good model, not without its tensions, but it was a smaller outfit, it seemed to have a finger on the pulse regarding some of the things we are discussing. But what I don't see some of the learning. WE talk about the learning organisations but I don't see how that is feeding back into the models that are emerging now. And I thought West Lothian were doing well at it because they employed as joint appointments the director of social care was also a joint appointment with NHS Lothian, was a member of NHS Lothian Board and was there for 5 years, certainly in the time I was there, but I never really sensed a different level of integration from that point of view. So I think we are going to see continuing tensions with no clear answers to lead agency or corporate body status at this time. And I think that is going to remain the challenge as we focus in on that.

And just going back into that regarding cultural and operational stuff, one of the common issues that has always been raised besides T&C's, besides a common role, is this notion that care is a 24 hours a day 7 days a week business. Until Saturday and Sunday in health and social care becomes like monday and Tuesday, I just don't think we are going to get the kind of flow through that the corporate bodies or the lead agencies are actually gona be looking for. That's another big issue that has never been addressed. It's that real sense that we have unsocial hours, we have shift work, yes care institutions have to be staffed 24 hours a day. You'll have come across the arguments that operating theatres that stand empty. We have diagnostic equipment rooms and equipment that go unused over weekend periods and after a certain time of day, because we don't work on that process.

Is that a service design issue or more senior or executive mentality?

I suppose it comes back to the big issues of context and its about what it is that we want. We argue that its for the patient and it's the patient first, its about getting the best outcome for patients. But that's also said against the notion of cost effectiveness, value for money which we can break down into various dimensions but in reality its about getting the best use and best of people. We have a huge demand on health services. IN Scotland as well as in England. That demands is not going to get any less and I think there is something about getting that balance about the context that is there. I don't think its about management mentality, I think its about service design more than anything. Because, management has to work with the context and it's the context that are changing whether that's political, whether that's cultural, whether that's operational. For me that context has to be realised and understood, and then management adapts to what it needs to do to deliver on that. IM also not convinced at all that management when it comes to those issues has got a clear sense of where responsibilities lie and therefore where their authorities lie and ultimately where their accountability lies in that sense. And that is very complex.

I was very interested in the finding relating to manager's operating in networks (*These differences cannot be realised until managers start to think about how inter-agency groups and teams are managed*

and taken forward as part of a network). Its about inter agency and about multi organisational relativity. I remember when I started with management training you could draw these separate circles and coding all these different agencies and draw lines and say "this is all the relationships that the manager had", but today you would have to draw that and everyone of those circles would have to be inter linked. They would have to be inter locked. Within each of those there is a common ground. Again it comes back to context. Managers need to manage and do what they do in the context in which they work. And those contexts are changing. In my mind its not about changing managers, its about managers understanding the context so that they can do what they do as managers in those different contexts.

Should we understand this context as a loosely coupled system or part of an eco-system.

Systems within systems within systems. This is an issue I always use to work on with managers and especially the CHP is a prime example. YOU might have a general practise within a CHP which is within the health board context which is within a region, which is within a national health service and so on, which is in a bigger government ethos. So its systems within systems within systems and you can't change one part without impacting on the others. But for me that is day to day context that managers are actually in. I wouldn't be able to name it. I'll come back to managers in that. But these are the things that were going through my mind. And coming to the point of (senior managers point out that managerialism has shifted with devolution and has become more collaborative. Management models carry lesser relevance as public services increasingly become driven by user focus. Therefore, service revolves around the user.) I suppose what occurred to me in that is this sense, using an analogy, thinking of the adult manager or the grown up manager, the experienced reflective manager, who has got there by going through larva stages and pupa stages. So reflective practitioners, becoming a manager of reflective practise and working within those contexts. I remember working in a hospital and the only thing I worked in was within my collection of wards that I was responsible for. And that was my focus. I never actually appreciated at the time that I worked within a unit, within a hospital, within a region, within a health service. I didn't see that. But now you see the bigger picture all the time, you see where those issues are and I'm gona come back onto that in terms of managers.

2. What types of Training & Development initiatives can prepare and support managers to work in inter-agency networks and deliver joint services in ~~the future~~

Regarding (*Managers are working in a collaborative and political environment where there is a need to understand the larger political agenda and the inter-dependence of agencies*), my question that that would be: are they and what level and do they know this? I'm not convinced that they do but that also ties in with my point about how grown up are you as a manager and in terms of where have you reached in your level of behaviour which lets you see all that bigger picture and think, "no problem I can see it, its ok, I know what to do, because there will be points in that process where you see that and you focus to that and you think you know how you can work with that. So for me, its that, at what point does the bigger picture become appropriate for managers, and I know that ties into how we train people into the future but I think if you're talking about the state, the state we are in and where we are going to then YES, it is a political environment and managers need to understand that. I don't believe managers can afford to be apolitical. And they need acumen, political acumen, they need to understand and know what are the drivers. Politics with a small p, politics with a big P, whatever you want it to be, but it is going to impact on where they are at. the question is asking how are they doing that. And I think it is either a conscious and active engagement or it is that sense of "not quite clear what is driving that but I'll go with the flow anyway". I know we can go back to all those models about unconscious competence and conscious competence and that kind of business but in the reality of it is that it's the context, its where that manager is and what it is they are actually doing. And the thing that keeps leaping up is about the 'professional manager'. It is about "this is it, and I'm a manager, put me in there because I

know what those issues are” as opposed to “as opposed to “I’m just responsible for a group of people and a function and that’s all I need to worry about and that’s all I’ll do”... and that might be okay to a certain point but its not gona make any kind of impact on these kind of bigger issues unless we are enabling them and seeing their way through into that bigger picture. I suppose that comes to the point of, do you actually want professional managers that are recognised as professional managers. Because they have a certain skill set that actually allows them to engage with this kind of stuff. But in reality you’re working with people that are coming up through the system, that are working within the system or systems in a changing context.

Might this suggest that you can recognise the skill set required but avoid define or give boundary to the role?

I think that’s absolutely right because the thing that occurred to me when I’m going through this, is that its very complex and there is some license to operate differently, and again that’s contextual as such. But I don’t think you can prescribe what it is that defines that management role. Managing implies a people element all the time, otherwise its becomes very technical, very scientific and its probably more predictable, but because we are dealing with systems and processes and people, then it is so unpredictable from that point of view that to have a boundary becomes almost a brick wall. You know 10 years ago, health service plans in Scotland and in England were talking about shattering demarcations between roles. So maybe the way through that is this sense of partnership of inter-agency working, about not being as precious. I work in an organisation (anonymity requested) where there is such role preciousness and I’m wondering about the barriers that it creates, because it doesn’t make for shattering demarcations at all, it really does make for those kind of blockages. That’s the nature of what we are about to service, we are role and task driven, we have JD’s we are told what the limit of our job is. How therefore could I actually organisationally develop myself? How can I push those boundaries if I have a limit. I understand the need for that and I don’t have a problem with that, I suppose its actually good to have a context for the job that I’m actually doing. And I know that when I start any job as I have in the past, this notion of the role and yourself. And when you start a new job the role is paramount, and there’s just a little self down there. When you get to grips with that role, you start to bring other things into it about yourself, so the self begins to grow and the role begins to shrink, because at the point, the role begins to push outwards. And for me that is where the boundary shattering thing actually starts to happen.

I mean, employers like to know that they are employing somebody that knows what they have to do which is good. Its absolutely right that an organisation in Scotland like the health service that’s employs a 160000 people or more has a real sense of expecting what it wants from people that it employs and asking them to deliver against a fixed agenda. That’s fine, but I think we are talking about a different context. For me it is about that changing environment and changing context that people find them in. And this is only going to happen through people and its only gona happen through people who are leading and managing, if we are going to get that level of true integration.

I agree that managers facing increasing admin even with improved technology. But that for me is something about managing one self.

(Interaction, exchanging of information and practise by doing are key to understanding inter-agency perspectives and pressures) – Absolutely, but the thing there that needs adding on is the notion of being a reflective practitioner and reflective manager. The other side of that coin for me is that managers don’t value reflection because they are more driven by achieving targets than they are actually taking space to reflect on what they are done. And so reflection becomes an add on to rather than an integrated

part of who they are and what they do. And that is reflected on your finding on the lack of time, space and opportunity for that. So its that very sense of 'why is not a period of reflection as important as this spreadsheet that I'm doing to show how I'm meeting the targets of the day.

In the case of 1 chp and board, it allocated about 8 hours annually to go away and be part of an action learning set, so that's built into the job spec. In the other 4 board it wasn't. Hence if managers wanted to do it they had to use their own initiative and make their own time.

I mean that is interesting and my instant respond to that is to be become ANGRY. That a board could actually "dain to actually build in 8 hours reflection time, how dare they". And I suppose that's the point for what the future of Management Development is about. If you want people to grow and develop and deliver this agenda, they you really do need to start prescribing for exactly what that role is. And you really do need to give people the space. And I don't mean physically saying "I'm gona give you some time off". I think its actually enabling managers to create their own space legitimately as part of their role. Not as bolt on, not as add on. Its about saying "atleast once a week I'm going to take 30 minutes out and the end of the day, the door is hut, the phone is shut, and this is my time". I suppose its really how we get beyond that traditional executive management mentality that people have to be doing something. A great phrase for me was "you look really busy to me. How about some results instead". The bottom line issue there is that we look busy and managers believe they need to be busy but that does not equate in anyway what so ever to output or result or effective or quality care or quality outcomes at all. So, it is about reflection as critical and it goes back to the point about middle managers (3rd point) – they do seem to be the group that are "damned if you do, damned if you don't". they got pressure from the top and pressure from the bottom and they seem to be the people in the middle. But for me that is the most exciting place because its that sense of being able to influence upwards in terms of strategy, in terms of policy but also being able to influence downwards as well and learn from that perspective. So it is context.

That takes me into the fourth point (Long term success for joint working and integration of services will depend on managers making that transformation and transition from *single-organisation management* to operating and managing in *inter-agency networks*)- for me that Is about behaving accordingly. I've been doing a lot of work in the ---- and it reflects to me why I want to work there, because it is about not prescribing, its about ways of behaving within contexts. And that doesn't seem to set any boundaries, it does seek to prescribe, but for me there are a number of areas that I can say out:

Personal Resilience is the issue, day to day managers have pressure on them and its how you bounce back and its how you work with those issues.

There's about courage and integrity – acting with courage and integrity. "Look at all these systems. I need to work with this, I'm not sure I'm ok with that. Am either going to say that or I'm gona go with that. But its that sense of working within that sense of a code or conduct which gives them a sense of integrity in the things that they do.

The other thing is about working with confidence, have something which grows, is about working with authenticity with other people and that's something I think middle managers struggle with. IN middle management particularly everybody underneath them is giving them hell if you like, and its that sense of saying I don't know, what are your thoughts about that, let's try and work it together. The other things are about resoluteness, about having problem solving, its about change management,

and then its about consistency. And that consistency is about generating me time. Tats whole reflection issue so that you can tackle things differently.

So about making that space and time?

Yes absolutely, absolutely

With the other bullet points, they come around resoluteness, around consistency, around those behaviours its about acting with. The reality here is the dimensions that people work with for managers, this may be a false breakdown, but if you want something just to help them work with it, we have got managing yourself, managing people, managing the service, managing the organisation. Its **what you are doing** as a manager when you come to work. It's a false separation I acknowledge, but you can actually see the emphasis of where it is that you are actually working with. And its just about behaving, acting with, certain behaviours. Because it doesn't really matter then what the context is. You need to know about the context you need to learn about the context and it occurs to me that in the past, managers have almost been passive recipients of management development. Oh 'you need some MD so you're going to do this program. We going to do managing change and so on'. And I think, WHY (In amazement), What is that about (in amazement). If you turn that on its head and say "you expect managers when dealing with people to be authentic" and that really is about being fare, its about you and me having a conversation, its about recognising that we have job dimensions that we have roles, that we are responsible for different things, but still its about us having a conversation about trying to get things done, coming up to the same conclusions, its about working with difference, its about managing conflicts and where there is tension its about that productive friction that is there, its about working with it. Acknowledging that we have different views and not pulling out. Its about saying "that's really interesting I had not thought about it that way, let's sit and work out something". So hey, you don't actually need to go have a training session on communicating with staff or working with partnership, because lo and behold, if your acting in this way, THAT is actually HAPPENING. SO "how about acting with resoluteness because you're a problem solver, your managing change, tell me you genuinely know what to do and how to do it". People look to you for that kind of thing.

So what are the kind of models that you want to use for that? I think there is a difference here between management in terms of 'management' training like managing staff etc. but when you're talking about tools, if you're struggling or you're going to manage change. OK well there's lots of tools for managing change. There's Lewin, there's Carter, there's all these different models for managing change, yea learn about them by all means, but at the end of the day it's the way that you are behaving more than anything.

Professional identity, increased recognition and increasing memberships? Does it cause trouble to the collaborative working agenda?

Yes it does. And HR is a brilliant example. We should be dealing here with creating teams and workforce teams by design and not by default. That's a key issue we have got here. If you take a typical ward or general surgery, and if you have am ex number of nurses, doctors and so on. But in reality it really is about putting people together in terms of what the patients pathway is and what the patients outcomes actually might be. That for me comes to managers as well. I think there IS a false separation, and it is the standard isn't it. HR is a good example, CIPD and so on. I am a nurse by background but I ended up working in a HR function. I have got management qualifications, I have got teaching qualifications, I've got professional ones, but I worked in HR and wasn't recognised as a HR professional. I'm in training and development and OD but I am not a member of the CIPD. So there is NO WAY, I'm ever gona achieve a director status on a board at that level of HR because I don't have CIPD. Just like I would never make a chief nurse if I didn't have a registered nursing qualification. I suppose the challenge in all of this is, what is it that we are asking of people AT THIS LEVEL to create that level of integration. And it is for me fundamentally about knowledge of the contexts in which

people are working. So it's the question that leads on is how do we prepare managers for the future? I don't think it is about giving them a session about change management. God forbid that we still are recruiting or appointing managers that don't know how to manage change or don't understand employment law or the questions you can ask in an interview. WHY are we doing that? Why do we employ people and spend thousands and thousands pounds more training them to do the job that we have already appointed them to do. That is where for me the differentiation about what a manager is, who a manager is and what they are doing. What is that skill set? What could you expect as an employer of me as a manager? What can you relax about? Would you not when you employ me be more than content to know that I can do all that as I'm a professional manager, I know what I can do and can't do, I understand health and safety, I understand risk managing , I understand change managing and I can do that. What is it that you want from me that will help you to relax in the knowing that I BEHAVE appropriately in the context that you're asking me to go into? That is fundamentally what it is about. I can go to any session I want. You can put me in a room with x number of organisations because we have to work together and I'll relish it and soak it up and I'll be interested and I'll want to learn because that is knowledge and comprehension for me about the context in which we are going to work. And FROM THAT I can see "there's the interesting challenges, there's going to be the issues". IM not thinking "oh my goodness that's never going to work, we are never going to do that". But why is that about me. Is it because I'm experienced or is that because I want to work and I want to act in a certain way with those challenges..... "I've got resilience and consistency to learn about different kinds of issues and I know how to manage the contexts then bring it on" is the point I want to make here. It is not about prescribing what these managers now need to work in a changing integrated environments. If anything, all they need to know is to understand, they need knowledge on that changing context. SO let's sit with our social services colleagues and look at what their aspirations might be. Let's see both the sides and options that we can work with. And let's agree on how we want to do that. Whether that means me as a health service manager needs to come spend 6 months in social services and vice versa, or we need to work jointly and body up on these issues, and it might be that we work on particular projects and our organisations are gona let us do that for 6 months to come up with a solution. The thing about it is, it's not just lip service, but WE DO IT. But I don't need you to tell me though how to manage change in doing that, or to manage risk, I just need to know that I can ACT APPROPRIATELY with the people and the context that I am actually working with. So no prescriptions thank you very much. I actually need to think "this is what I did today, did it work, if not what didn't I do well, what went better than others, what might I do differently. What have I LEARNT about that? What will I do differently tomorrow? What was the high spot of that day? What really was low that I won't repeat again because I've learnt?

Is it about the right personalities then?

I'm always a bit cautious about personalities. Because personalities are so vast and different. You can have a very quirt person who is very effective, or a vagarious person who is also effective. At the end of the day it's about how they are behaving more than anything..... 43:00

I've been looking for managers to be intrinsically motived. That's why I struggle with any organisation prescribing what its manager should have.

I've worked within those contexts as well. I remember us reworking with this notion of a passport to management. And it was all this kind of people management stuff. SO it was to do with managing sickness absence, managing recruitment and retention, having difficult conversations. And I really struggled with these kinds of concepts as such. Because for me, it's about behaviours and I keep coming back to it.

I think we need to respect managers for trying to achieve what they need to achieve. They are tasked by organisations and they need to be allowed to do that. And if anything they need to be reflectively facilitated to say look, how you developing your resilience in terms of the pressures you are under. What does that mean to you? What are some of those issues for you? How is your confidence in some of the issues? And that really controversial point about “what can I be doing to actually make things better for you, what do you need for me”

So we have talked about no prescription in terms of L&D needs and being behaviourally focused.

3. Can informal learning be facilitated in some structured or planned manner? How?

I think we DO need to move away from a traditional notion of a programme with some taught content. I think the future is about behaviour. It is about facilitating reflection. It could be about – I hate the word action learning sets, but there’s nothing wrong with having healthy conversations. People need to be encouraged to select in a way that they can think will help with things. So not restricting to a coach or a mentor, I would approach and use anyone in the organisation who I think would be able to give me advice with an issue that I was working with. So I had loads of mentors and I use to go see them and I think that was a really useful way to do things. But the other parts of these programs is that we need to think differently about what that program is. What is that program, for want of a better term, has this notion of ‘voice of manager’. So when we use to do Lean Management we talked about the voice of the customer (VOC). Let’s assume managers are customers then, what about the voice of the manager. Why don’t we actually a facilitated approach? When is it when managers meet the chief exec or meet directors and they thrash through some of the issues, they raise things that are working and talk about through some of the stuff that is helpful and not for the organisation. And again its more about helping THEM to become more resilient, develop more confident. They deserve to have concerns listened to. When does that happen and where is there voice actually heard? And I don’t mean team meetings, I don’t mean departmental meetings or the training programs. Instead of training programs, why don’t we get the chief exec come meet with groups of managers at certain times? But in reality it’s just about that CHANCE to talk about it. I am talking in terms of facilitated reflection. Helping conversations if you like. And IM not using ‘coaching’ or ‘mentoring’ as I’m not looking for definitions. Its about generating mutual confidences. Mutual sense of resilience. Managers work within a context and not within a vacuum. They are not on their own and there a real sense that they are not passive recipients. Managers don’t get development DONT to them or they shouldn’t have. They have gone beyond that now. We know there are lots of MD programs out there and all this kind of business, but for me ultimately, if anything, I’d be looking to help managers assess themselves against a meaningful framework to them. That means something to them. We use dimensions on the sense of self for people, for services, for organisations, we have basic competences that associate them, but we have this behavioural framework. Nothing is prescribed and there are indices which say you might do this or you might not. What I’m always saying to people is, always look at yourself in the context in which you work and which of these would be most helpful, and do you want us to work some action plan through and make some recommendations with you, but reflect on it. Its not the only framework in the world, there are millions of framework out there that managers might want to use, the Scottish leadership framework, the leadership academy etc. it’s all much of the same thing. At the end of the day though it should be about a manager who accepts that they are a manager. It’s a choice. DO we get into the debate about being a manager or doing management? Because I’m not sure that everybody can be a manager and again that’s more about responsibility, authority and accountability and understanding what that means and taking that on.

I keep using the words Context, then using the word knowledge of context, then using the word reflection, then behaviours.

Would there is weight in the suggestion that can’t ignore the local context in the case of delivering integrated services?

That is the point. If a manager says to me I need MD, my first word is, describe the context in which you work. Tell me the context in which you work. And people struggle. Managers struggle sometimes to articulate the context. On the one level its about the day to day job and who they report to. What you're hoping for is the level beyond that and the level beyond that. Perhaps an insight into a level beyond that. Because that turns the whole issue of MD on its head about what it is they are meant to be doing or achieving. Half of the time its "I'm so busy I have to do this and that" Ok "well what about time management tools then. That's gona help you ". But that's not about you as a manager, that's about Management. It ought to be about managing yourself because if you don't get that right then your behaviours are gonna be of.

Getting people to define the context for joint service delivery or integrated service in their respective CHP's, there level of understanding is pretty critical to get that level in terms of their own growth and development because I don't think organisations are going to be able to develop them. And that's my point about learning about the context and understanding the context in which you're working and then decide what kind of behaviours, how you need to act in that context to get results. It might be about acting more with political acumen and that is about network and stakeholders, so straight away when you talk about integrated care, they are already thinking in terms of stakeholders and networks: as in who do I need to keep happy, on my side, who I need to keep informed and who do I want to learn from. WHO are those key players for me? THEN we start seeing development, then we start to see managers growing to manage the context in which they are in.

What might future legislation and policy encourage in the way of facilitating Management Development in integrated public services?

This would be my most disappointing or negative sense of what to say, because I don't see policy and legislation facilitating any kind of MD. It may always stay vague would be a constructive way of putting it. Policy will be policy and I don't think policy makers or legislation makers don't think for a moment what it means for the people who have to manage it. I think they look at their big strategic context and what they think might work. And then they look to people to deliver it. I don't think they see it as their job to tell them. Policy doesn't say how its gona get delivered. Policy thinks it looks good. And when I sit on my podium and tell that to my electorate, because that's what they want and that's gona work to keep me elected and that's gona keep me in the position of influence. In the lean term, its "hand off". Over to you guys then. SO what do we come back to again, we get the policy context. So managers, understand the context in which you work managers because that is what will drive the way you work and the pressures you are under. Know the policy that is there. In Scotland at the moment it's the 2020 Vision. Its beautifully set out and colourful. Its got the quality side of it its got the deliverable side of it and you can see it terms of your professional grouping which ones are important to you and which ones you need to be focusing on. So there's a real sense of re assurance. There future is already here. Its just policy. So we are taking here about MD in integrated public service delivery. The policy and the legislation to some extent is going to be about integrated public services. That's telling managers then they are going to need to work within integrated contexts more so than they are doing so now. But I don't think they can look to giving them any sense of pure development. What they could do is reflect a little bit and think about what will this actually mean and how will I be working differently. And there's always that stage where there is policy, and then there is the period of time there are workshops and conferences about what that's going to look like and how we might work together and some case studies that are meant to fuel or lead to new ways of working. I'm not convinced that they do but they do provide food for thought. So do we class MD as attending a conference, do we class learning from that as development? If anything the policy generates for me maybe some contextual learning but that's all it is.

There is the challenge of how you classify MD on form and content related to an org or sector.

My view is the broadest possible about MD. It isn't for me just about you do your job and there's a bit of time for you to have your appraisal, think about what you want to learn about. And it is so false, so pretentious. It's condescending.

What planning is in place by T&D providers (i.e. The JIT, IHSM and NES) that can address the needs of collaborative partnership working and increasingly integrated service?

What I believe about this is that if we accept this sense of self-motivation, reflective managerial practise, mapping development against a framework that is behaviourally focused which is about learning about context. But in addition to that, it is about acknowledging that managers need voice they do need to be able to be represented, they need to be able to look to organisations to represent some of their concerns. The challenge is how do we clear those concerns. How do we bring those concerns together in a meaningful way which can be caused at the right policy levels?

Its also about forward thinking organisations wanting to hear what managers are saying and acknowledging the work that they do. And also it's about encouraging networks for learning. The whole point here is that you can choose your own learning networks but there's also a great opportunity in integrated working to extend and expand those networks. I don't think there is any clear planning in place. You can't talk about things like succession planning and talent management but what are they spotting? Are they spotting people in readiness for integrated working or just replacing the same with the same?

Any planning by providers or the NHS itself for the upcoming integration?

I think the difficulty we have is that the NHS is pretty much chaotic but its got a health and social care bill in England which is confused to say the least. Its got a massive funding deficit and its not getting any better. In Scotland they are in a slightly better position. I think there's a bit more focus to where its going but they are still facing similar fiscal tensions into the future. I don't think its possible. There is nothing tangible to plan for other than 'do the same for less'. And decisions will have to be taken about what shall we stop doing because there isn't going to be enough money to deliver it. I don't think you can plan a strategy for that. Because its going to be locally driven, demographically and regionally driven. Which is why I think the future is already here. I think what you can only plan for is enabling managers to grow with the context to whatever it is changing to. BY enabling managers I guess to continually reflect how they are working with a changing context should be the plan. Transience vs resilience are the two issues because health service policy, frameworks, legislations are transient. The government is transient. The next 3 to 5 years it will change. So what is it that people need to sustain, to be resilient about, and fundamentally for me that is about behaviours. Its about how they conduct themselves in those contexts. Its not a tangible that "this will happen in this context". It really is a movable feast and it is transient.

We can have the tangible stuff. There will always be a quality initiative. That changes 3 times in the 8 years I was working in Edinburgh. And I know that NES has had a leadership framework. The NES Leadership stuff use to sit with the government, it got moved to NES. They run a developing future strategic clinical leadership scheme. There are action learning sets, there is coaching about that. YOU could always have them, the tangibles. But that future is transient but its already here. In 5 years' time there will still be policy, still be legislation. Hopefully there will still be a national health service. We still need people to work with resilience, with authenticity, with resoluteness, with courage and integrity. Those are the things that need to be sustained in managers. For me that is the plan.

At the ground level for service managers that manage teams delivering services, what does this all mean?

It's all very fragmented. We have workforce planners deciding how many staff we need without any reference to what sort of team it is that needs to be delivering. And they work in isolation from this that and the other. It is much more about managing disparate teams. In integrated pathways and in multi-agency working you have teams that are spread not necessarily co-located, but spread. So what will it mean managing teams that are like that? It's hands on for the manager very much so and much more so than it ever has been and I think that's the nature of integrated working. I think what we will see is small senior teams. There will be a chief exec I'm sure, who'll have to accept that the buck stops with him/her but might need different levels of intelligence to enable them to work differently across that. You probably still need HR, partnership. In Scotland that's pretty fundamental. We'll see incidences of good practice, pockets of joint working. I just don't see wholesale integrated H&SC. Without the fundamental tackling the issues of the people side of this. When everyone goes on about putting patients first, I think sometimes you have to put the staff first. If staff are our greatest assets, well I'm afraid staff are also your greatest constraint if you don't get that right. And it's about getting it right for them and the rest will follow. And that's been the bottom line in every major policy document that's come out which talks about quality of care, outstanding outcomes. You get none of the above if you don't get it right for your staff. Because I actually believe they want to come and deliver service in this wonderful healthcare system we have that demands people are engaging with people. Unless they feel supported and content, if they side track all the time, that he's getting more than me, that I've had more training than them but they can do different and better things than me. I just think we are just such a long way off. They are putting the cart before the horse. Integration is still for me a "fabulous aspiration and we should have it in there". The greatest danger is not that we set our goals too high and miss them, but we set them too low and reach them.

I'm glad you raised the role of HR and HRD. Because what right does a HR or a HRD function have to do MD.? What's its license to do that? What is its learning or knowledge base? It's just not. Human resources. I've worked in organisation where human resources was a support function only. Didn't have a HR, no director, it was just purely that we got the admin side of things right. I recognise that in Scotland partnership is entirely different to England. I think partnership in Scotland is marvellous. I was really impressed that that kind of dialog goes on. I think probably the answer is in partnership.

Emerging findings from Phase 2 and 3 shared with field expert prior to open-ended interview discussion

1. COLLABORATIVE WORKING AND INTEGRATION OF SERVICES

- There is concern about different the Terms and Conditions of Employment for staff between agencies which will create inequalities in remuneration. To certain extent, this is observed as a limitation of collaborative inter-agency working and joint service delivery.
- The need to develop trust and cooperation between agencies is vital and there remains differences among agencies that must be addressed. These are:
 - ❖ Cultural
 - ❖ Operational
 - ❖ Administrative
 - ❖ Political
- These differences cannot be realised until managers start to think about how inter-agency groups and teams are managed and taken forward as part of a network.

2. EVOLVING ROLES AND PROCESSES

With reference to the role of managers and the work processes they engage with, the following outcomes are observed.

- Managers are working in a collaborative and political environment where there is a need to understand the larger political agenda and the inter-dependance of agencies.
- Managers face a forever increasing administrative and clerical role even with the increasing availability of improved technology.
- *Interaction, exchanging of information and practise by doing* are key to understanding inter-agency perspectives and pressures.
- Particularly, middle managers face multiple changes related to role and procedure and are the group most likely to resist the change since they are neither driving strategic policy or agenda, nor are they on the ground level where the service delivery occurs.
- Managers will need to work beyond their accountabilities and become influencers of change in a complex environment.
- The leadership challenge for managers will be to facilitate joint service delivery and not let structures get in the way.

3. MANAGERIAL LEARNING, TRAINING AND DEVELOPMENT

- Managers and the Organisational Development (OD) function are conscious that training and development (T&D) must facilitate the transition of managers from *managing in single organisations* to *managing in inter-agency multi-partner networks*. At present this does not happen as T&D initiatives focus on enhancing and/or supporting performance only within the organisation.
- Budgetary pressures and constraints in public spending are curbing opportunities for Managerial T&D – making it harder to find money to deliver Management Development programs.
- Job reduction and the hesitation to replace vacant posts discourages a programmatic or systematic approach to managerial learning and development. This is due to constant state of overspend and increasing demand of public services which create budgetary constraints.
- There exists a desire to better define the professional managers role in integrated health and social care services .
- There is strong consensus that *learning-by-doing* is appropriate means of training for inter-agency management. the following suggestions are welcomed:
 - ❖ integrating *partnership* specific and *network* specific L&D needs into yearly work plans of the manager.
 - ❖ Peer reviews and mentoring as part of professional development plans which are made available into diary time.

SOME THOUGHTS FOR OUR DISCUSSION

- What might future legislation and policy encourage in the way of facilitating Management Development in integrated public services?
 - What planning is in place by T&D providers (i.e. The JIT, IHSM and NES) that can address the needs of collaborative partnership working and increasingly integrated service?
 - We can envision how the managerial role will change in the future. But how will managers cope and be able to deliver on it?
 - How can you create the opportunities to support managers while they go through the processes and complexity in order for learning to occur?
 - What kinds of T&D initiatives (formal and informal) can prepare managers for working in integrated services that go beyond organisational boundaries or networks?
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Annex F

Initial Coding Framework and Focused Coding Framework

Initial Coding Framework and Focused Coding Framework

Sample of initial coding framework used to code interview transcripts and initial codes were combined/amalgamated to develop a focused Coding Framework

Initial Coding Framework	Focused Coding Framework
<ul style="list-style-type: none"> ▪ Appropriate Governance ▪ Issues in operations ▪ Leading across different services – Horizontal Management ▪ Degrees of Partnership ▪ Formal Informal Governance ▪ Partnership Agreements as governance ▪ Legislation as formal governance ▪ Emerging Structures ▪ Pooled Budgets Vs Aligned Budgets ▪ The legality of integration ▪ Changes in legislation allowing integration ▪ Legality of word 'integration' ▪ Formal governance of joint working ▪ Partnership Agreement implications ▪ Informal Governance – outside partnership agreements ▪ User focus as service driver ▪ Promoting change as cultural agenda rather than structural agenda ▪ Uncertainty of organisational layout ▪ Uncurbed Service demand ▪ Evidence for integration as solution ▪ Realms of Culture ▪ Performance driven targets ▪ Lack of understanding at executive level ▪ Fixated on targets ▪ Change in management ideology and practise ▪ Bottom up change ▪ Audit Culture ▪ Bureaucracy ▪ Rational Managerialism ▪ Structuralist agenda ▪ Form follow function ▪ Deluded ideology for structure ▪ Purpose of change ▪ Joint working but with different T&C's. ▪ Structural change as by-product of successful joint working ▪ Devolving Power ▪ Exclusive co-terminosity pre and post integration ▪ Journey of Joint Working ▪ Process not product ▪ Common Purpose not multi-purpose ▪ Barriers in trying to manage ▪ Crux of the problem ▪ Culture differences ▪ Learning by doing ▪ Becoming One 	<ul style="list-style-type: none"> • Service Integration Purpose • Governing Service Integration • Service Organisational Models • Service Integration Challenges • Integrating of Resources • Integration Challenges • Management ideology • Top down vs Bottom up planning • Top down vs Bottom up implementation • Performance Culture • Culture of joint working • What change entails • Challenge for management • Terms and Conditions for Employment • User focused management • Localised management • Changes in roles, • Change in responsibilities • Change in relationships • Changing Accountabilities • Altering Skills and Behaviours • Opportunity for middle-manager T&D • Relevance of existing MD forms • Informal learning and development • Learning by experience • Altering professional identity and leadership • Evaluating managerial performance and development • Joint planning for Learning, Training and Development • Co-location Potential

<ul style="list-style-type: none"> • Significant change • Changing nature and principal of management • Models of Management • Linking at the ground level • A state of preparedness • Exchanging and interacting by doing • Understanding quality service delivery at front line • Better and best utility of money • Context of health service • Reporting in different systems • User involvement • Duplication of Effort • User led innovation • Levels at which issues can be tackled • Government helplessness regarding employment issues in integration • Questioning the plausibility of co-location • Co-location as tool for politicians and managers to showcase • Giving a face to integration • <i>Innovation through joint planning</i> • Opportunity to innovate locally but having to deal with national agendas • Coordination between T&D providers • Co-location as incorporating service functions • Stages of training during career • Learning to manage in political environments at different levels • Becoming influencers of change in complex environments • Developing common understandings between H&SC • Collaborative leadership approach as opposed to management models. • Integrating OD functions • Integrating T&D functions • Challenges of joint MD planning • Maintaining professional accountabilities • Barriers to integrating MD functions • Need to develop future T&D to develop leaders • Professionalism in Management • Reliance on national MD programs but using them locally • Supporting change in role • National agenda's affecting Managerial Development • Pulling L,T,D together in role • Piloting innovative work • Situated as corporate service • Interface for L&D function • Source of service and how/when delivered • MD programs fulfilling the cultural shift needs of integration • Project work facilitating purpose • Budgetary pressures curbing formal T&D opportunities • Programme approaches to MD • Traditional forms of MD • Managerial Transformation • Barriers to sanctioning other ways of managing • Succession planning for T&D • Soft Skills • Hard Skills • Value of learning • Tangible learning 	
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Annex G

Generated and Refined Categories for theoretical coding

Generated and Refined Categories for theoretical coding

Coding of data using the focused coding framework resulting in the generating of categories based on patterns and findings emerging from the data. Categories used to engage in theoretical coding.

Focused Coding Framework	Categories Generated
<ul style="list-style-type: none"> • Service Integration Purpose • Governing Service Integration • Service Organisational Models • Service Integration Challenges • Integrating of Resources • Integration Challenges • Management ideology • Top down vs Bottom up planning • Top down vs Bottom up implementation • Performance Culture • Culture of joint working • What change entails 	<ol style="list-style-type: none"> 1. Service Integration Purpose and Planning 2. Integration causing complexity and ambiguity 3. Understanding Cultures and Relationships 4. Locally driven joint working and national agenda for integration
<ul style="list-style-type: none"> • Challenge for management • Terms and Conditions for Employment • User focused management • Localised management • Changes in roles, • Change in responsibilities • Change in relationships • Changing Accountabilities • Altering Skills and Behaviours 	<ol style="list-style-type: none"> 5. Developing Shared Understanding and Values 6. Managers associating with delivering user focused services 7. Changing roles, responsibilities and relationships 8. Addressing barriers to a changing remit
<ul style="list-style-type: none"> • Opportunity for middle-manager T&D • Relevance of existing MD forms • Informal learning and development • Learning by experience • Altering professional identity and leadership • Evaluating managerial performance and development 	<ol style="list-style-type: none"> 9. Learning different to before for a new context 10. Lack of support for middle-manager training and development 11. Professional identity and grouping 12. Relational Leadership
<ul style="list-style-type: none"> • Joint planning for Learning, Training and Development • Co-location potential 	<ol style="list-style-type: none"> 13. Altering Skills and Behaviours 14. Co-location as opportunity 15. Joint Management Development

Annex H

Consolidating Categories into Themes and Subthemes

Consolidating Categories into Themes and Subthemes

The process of theoretical coding using the categories, results in their consolidation to subthemes and themes. The data begins to distinguish itself and findings begin to merge under themes.

Categories	Consolidating categories into subthemes and themes
<ol style="list-style-type: none"> 1. Service Integration Purpose and Planning 2. Integration causing complexity and ambiguity 3. Understanding Cultures and Relationships 4. Locally driven joint working and national agenda for integration 5. Developing Shared Understanding and Values 6. Managers associating with delivering user focused services 7. Changing roles, responsibilities and relationships 8. Addressing barriers to a changing remit 9. Learning different to before for a new context 10. Lack of support for middle-manager training and development 11. Professional identity and grouping 12. Relational Leadership 13. Altering Skills and Behaviours 14. Co-location as opportunity 15. Joint Management Development 	<p>Theme 1: Perceptions of collaborative working, integration and change</p> <ul style="list-style-type: none"> - Subtheme: Attitude towards Integration - Subtheme: Integration Purpose - Subtheme: Preparedness for Integration and Change <p>Theme 2: Managing with complexity and ambiguity</p> <ul style="list-style-type: none"> - Subtheme: Change Processes - Subtheme: Cultural and operational differences - Subtheme: Financial Governance - Subtheme: Different Terms & Conditions for employment <p>Theme 3: Service Logic and Value Creation</p> <ul style="list-style-type: none"> - Subtheme: User-Context based Purpose and Management <p>Theme 4: The managerial remit: roles, responsibilities and relationships</p> <ul style="list-style-type: none"> - Subtheme: Transitions in Remit <p>Theme 5: The learning, training and development of service managers</p> <ul style="list-style-type: none"> - Subtheme: Transformation in training and development - Subtheme: Transition in Leadership - Subtheme: New Learning and Management Development

Annex I

Samples of Interviews Processed as per Data Analysis Procedure

CASE A

Focus Group

Phase 3

[REDACTED]: Head of Physio Services
[REDACTED]: Previous Deputy GM
[REDACTED]: CHP localities manager
[REDACTED]: Head of health Improvement
[REDACTED]: GM
[REDACTED]: Associate Nurse

1. How can opportunities be created to support managers in their learning as they go through the changes of health and social care integration (CHCP formation) in Fife?

In the journey on integration, I would agree that our product is the patient and I like to think that we are focused on that all the time.

Susan: What comes out to from it all to me is how we are responsible. How much by default do we give responsibility to other people..... there's the tendency to wait and see what happens and wait and see what's done to us from above rather than influencing it. So convincing executives to fund to support and fund learning, well how much of that could we do ourselves as opposed to waiting for somebody to put a structure. Its not necessarily even about the money, it's the actual taking people out of roles to look at specific things for a certain amount of time. It's the human resource opposed to the actual money.

[REDACTED]: And that kind of comes by building trust into your learning, building the trust has got to be critical as we move towards health and social care integration next year

Letting managers lead the integration?

[REDACTED]: We have been quite good at that. Its about form follows function. Because we have dealt with a lot of working services in Fife, we need to make sure that is factored into the learning as we build a H&SC partnership. So I think managers at the ground level feel more empowered that they are building some of that structures at the ground level and there is evidence there of a bottom to up approach.

[REDACTED]: Most managers are now working outside their comfort zone so when you're working at that level there have to be parameters of where your responsibilities starts and stops and as long as they have that, then can then shape on new models.

[REDACTED]: Some of it is about having discussion about what the future will hold and how you develop models of care around integration. But then you have got other things that kind of jut emerge and become central to change. And its how do we articulate that and do we manage that kind of risk. Its about that balance between innovation and risky practise and understanding things I guess.

[REDACTED]: Managing existing pathways but developing new ones as you go. That is where the skill is in looking at the risk in changing pathways or developing new ways.

[REDACTED]: All of that does come down to governance.

[REDACTED]: Putting patients at the centre in everything that we are doing. Any changes in pathways should be of benefit to patients.

[REDACTED]: There's the clinical governance and then there's the governance of NHS Fife and the Council.

[REDACTED]: So far the discussions have been based around the financial governance

[REDACTED]: It is the driver at the end of the day because that's the one that gets in the way at the end of the day.

Thinking of Exclusive Co-terminosity – 3 CHPS will merge into one CHCP. DO you think that is of advantage or beneficial for MD

Strong sense of user focused user led services + locally driven services

See integ as opportunity to innovate services for users

Confidence about joint working and a positive outlook on integration

I think it presents challenges due to its sheer size for a management perspective. I think it's potentially helpful around the resource that might be available across the board but I think its beginning to dawn on people that we will be the biggest H&SC partnership in Scotland. The only other partnership of a similar size that is exclusive co terminus is highland and they have gone for a lead agency model but they have split. Most partnerships will have populations of 140000 and budgets of £150 million. Our partnership will have a budget of about 400million and a patient population of over 300 000. This presents a challenge because it's kind of like a big bruise of joining the party you know between the health board and council.

The co-terminosity is always seen as a positive because we only have one council. When your in an area with 3 or more councils then its seen to be more difficult. The challenge for us is being big but being able to manage local. Locality stuff and fitting that in with the council and hanging onto things like our health improvement agenda at the local levels. I think that's a big challenge for CHPS because health improvement is at the centre of what we do. So I think that's the biggest challenge when you read the guidance and keeping GP's engaged.

Any joint MD?

There has been for some time a collaborative leadership program In life that brings together health and council people which a number of people have been on. That has been a long standing thing.

Theres also an Action learning Set funded thru the JIT for the senior managers but I have to that become a tick box exercise because we didn't collectively agree that we needed it and didn't shape it, then theres been that variable input. Some of it has been helpful. Because we didn't decide we needed it collectively, and shape it, then we've not used it to its full advantage.

What came out of that we weren't too clear about.

theres been a number of sessions. Has been helpful to work out some of the stuff that others did, but other than that its not been a success.

How often were these action learning set meetings?

it was like 5 sessions but it was a tick in the box exercise.

DO you attend any joint planning teams meetings?

well there aren't any. That's part of the issue. There is an intention to have. Because what happens at the moment is that you have the SMT in the health board and you have the Social Work management team in the council and we don't meet. But there is a health and social care shadow board. So reports are done into that board but there's no discussion across the management teams that inform our kind of organisational management plan.

At this point there is to be a significant change to the shadow board.

Well Yes from the Shadow Board point of view we had 8 members from the council and 8 from the NHS. From the council it was all councillors and from the NHS it was mostly Board members as in executives, but we lost 13 board members with the closure of the pilot for elected members so as a result there is now executive and non-executive members on the shadow partnership, so that has changed. SO it's almost like having pressed the re start button on that one. But there are discussion on how to have a more appropriate mix of senior managers in the overall project management rather than one person being at the centre at the moment who is just trying to sort out agendas for the shadow board. And working on some of the work streams which are focusing on the elements of the work but not an overall project management team as such.

There has been an overarching OD plan which makes reference to but we've not actually moved on that yet.

There is awareness that things are going to change come 2015, and people are looking now at the 12 to 18 months timeline. There is a significant number of posts certainly within this CHP becoming

available. And you can see maybe as time goes on there is going to be more posts either not replaced or replaced on an active basis, which could if we are not careful could give us an issue of capacity and capability as we move forward. And there was bit of that when we went from LHCC's to CHP's and I'm just conscious that the length of time it took us to get back upto speed... there's the danger that the service slows down or that as we actually create the new CHCP that we from the NHS point of view may be seen to actually lack capacity and capability because it that's not coordinated, and from discussions last week just demonstrated that it is not being coordinated across NHS life for the 3 CHP's so if we all do our own thing then there is a danger that we will lack capacity. So instead of building workforce and preparing them for the future and the new way, we may actually put ourselves in a difficult position.

T5: With the kind of posts coming up that we are unlikely to fill people with the same level of experience so even if we do fill them there's still some catch up time.

Pauline: If we have this huge beast then how is it managed at the local level?

10: In spite of anxieties about management capacity, the performance of NHS against targets has been positive. You can see the innovation and change in services. We are actually still supporting staff at the local level to do things.

11: Coming from uni-profession to multi-disciplinary, now we are going to be multi-agency. And for those on the ground its understanding the processes of the people who we are working with, their roles and their remits and moving into that new sphere. And I suppose that we are ever so hopeful that as we do that, who has the best skill and who should be taking that role will merge. Change for my staff group is about learning the new processes of the people that we work with.

12: A lot depend on power dynamics and it comes back to the idea that if we are losing potentially strong experienced leaders at the more strategic level. Staff at the ground level can be potentially naïve and before they know there's a new process in place and agreed to and its maybe not what it could have been. I think that's a real issue at the moment.

13: The cultural difference that we have where we go along trying to build that.

14: What we are not use to is the politicians. IN the councils being accountable to elected members can be quite frightening at times. How agendas can change and decisions can be made because of the political dimensions, which is something we don't necessarily have in the NHS.

15: And service managers are officers within the council will always play to let you know what the elected member wants for that locality. And sometimes you're not clear of what their agenda might be.

T2: The integration effort needs strong leadership

2. What types of Training & Development initiatives can prepare and support managers to engage and lead in inter-agency networks and deliver joint services in ?

16: Even if not in its formal sense, there's something about the collaborative leadership program that we ought to be learning from. We need to take the key elements of that and how do we take that out to the wider cohort rather than the chosen few. Because there is so much we have to learn how the councils operate and their decision making processes and their thinking. And there's so much that council colleagues have to learn from us around clinical governance, clinical autonomy, accountability into the Scottish parliament, working in the context of the health board etc. So there must be key elements that we need to pick up and make that more widespread.

Does it need to be initiated by the joint board?

Outlook is positive despite complexity and challenges

Adjust to the nature of change in clinical services

17: Learning for learning from each other

18: Showing learning

at top level don't

No, I think it needs to be initiated through the senior management of both organisations. That hasn't happened yet and that needs to happen. And I find those of us that have any kind of voice at all need to push on that one. Some of it is trying to link up across fife at the moment as well.

yes, I think understandings each other's cultures and how decisions are made. Again the council work in a very hierarchical way, so their officers won't necessarily have autonomy but what they'll say is a elected member on a pad group, it sounds like a decision made very high up that has to happen and actually it might not be the best decision to happen. So as a NHS staff, you might feel beaten down that decisions are already made through authority at higher level form the council.

Acquiring knowledge by attending meetings

I think its important for our staff to ask to go attend these meetings. So that as things develop they fully understand the context and the culture because we are struggling with it even at this level so for staff that are more junior going out to meetings its even more difficulty for them to have that knowledge. Even though devolved to the local level it is still bureaucratic as there's 1 or 2 people up there.

Would the OD function from both orgs come together to deliver joint T&D on the integration agenda ?

That would be good but I don't think there is a OD function at the council. As we understand it they have more of a training function rather than OD function

I don't even think they even do any OD

even in the NHS, OD as a department only does a lot of what we do but at the wider L&D.

Theres the thing about it being everyone's business. And the terms we have made around locality planning and local management groups have taken us so far in terms of service modelling stuff and that's how the OD work is done now as we learn how to put a service together but in terms of growing leadership theres a bit of a gap.

Coming back to the issue of size of the potential CHCP and the coming together of the 3 CHP's. Theres probably OD issue around that as well.

3. Can informal learning be facilitated in some structured or planned manner at Fife CHCP? How?

I think we have to bite the bullet and any joint group we are part of we want to start having those conversations of how we are actually going to work together in the new world. And we haven't done that. We are still kind of on those different railway tracks and I think we need to start saying now, well we are actually gona talk about it and how are we gona make it work. But the difficulty has been of the different approach. Social work is very top down and it is quite difficult to have that discussion because they have got to seek permission from above and that's now always been straight forward because there is the assumption that that's gona get taken from above so what's the point of us sitting in a conversation. It's just a completely different approach.

That's where if the action learning sets if they had been set up in a different way would have been really helpful.

Having conversations at the very senior level is important thing to do given the differences. Because people, the closer you move to locality the more likely people are to work together and try and make things happen because they are focused on the patient or the service user. The further away you get from that, the more likely your to be focusing on structure and budgets and things like that. I think that bit at the top needs to address such things fairly quickly.

← Sense of ownership for L&D at all levels

Reducing the gaps in cross agency learning thru action-learning sets

managing expectations



maybe one of the things we need to do is to manage expectations of those above us around what we can achieve. These wonderful ideas about service innovation but actually unless we move into a partnership arrangement that has the least disruption as possible for staff, that provides the right kind of support for staff, for the reason that we have got to set up a management arrangement in such a way that is supporting, and if there is a gap that's what we have got to fill first. And then when you're there you start to look at what you can achieve. If you try and introduce too much innovation or expect too much too quickly, then some of it actually getting to first date, it's actually getting into 1st April 2015 that we know roughly where we are and what we need to do, but let's not expect too much.

to say the lead for sense making at the locality level

Will be for higher level governance, but not at the operational level as we will have to deal with so much paper work around policy and paper work, many of which will impact our staff over time. So we will have to do is look at the gaps and overlaps and look to review them to make them meaningful to both sets of staff. It's a tricky one since there are clinical policies are entirely around clinical stuff, then there are HR policies that will be different because they are still different employers. Then there will be service guidelines that will be ones that we will need to bring together. So we are going to have quite a complex set of arrangements.

A sense of what needs to be done

It's not just the trust or accepting each other, it's about issues of confidentiality and software and how we manage demand that also gets in the middle of all that. Council manage service demand in a very different way than us and don't have the kind of national targets that we have.

4. Considering the benefits of co-location and acknowledging it as a collaboration effort, how can it be used advantageously for joint learning and training in the CHCP partnership?

I've seen health on one floor and council on another floor and that's called colocation. And that doesn't work. It would be useful where if the services are all delivering the same thing because they'll then naturally start to learn together and to develop the service together.

I think it will depend on what we are talking about and what level.

The T&D function itself is tiny and you may not see it even if it's there as you don't recognise it since it's part of what we do and we pull down our resources as when required and based on capacity.

The T&D has to be available to them as per need and doesn't have to be in a building.

Was that around integration and the service manager?

It was all about integration. But not the service manager..... My view is that it is not that connected with what we are trying to do. It is all quite strategic.

Any reference made to the work of the social work officer in integration?..... The chief social work officer's role is slightly different because there are 4 statutory roles in the council and one of them is the chief social work officer so even with integration that is a standalone role that will continue, that will never be part of any corporate body, that will stand alone as a statutory role within the LA, but I was just interested to see if any of the other LA had raised that as an issue or if there was any discussion about that person would sit out with the integration agenda.

We had some GP surgeries that had social workers and home care managers located in the same building, that was very positively received by GP practices. 10 years on they continue to say that it worked better for patient care. And there is a hope that as we move towards CHCP, that they reinstate some of that co-location, but is not then certainly closer working

Integration
is perceived
and envisioned
as a means
to improve
service for users
at the
local level

But again it comes back to the point of what level because if we are talking about senior manager level where you are responsible for hands on care. If you are going to have integration at the local level there is the chance here to really use it as a real opportunity. Lower level at the organisation where we are delivering services, moving on from the multi professional working that we have got to enhance multi agency working

And that's because that is where the difference for the patients will be. We need to put in place a framework to allow staff at that ground level to actually do things that can make difference to the care.

And involving the independent sector, especially the independent sector because they have a huge role to play, not just the voluntary sector. Particularly when you are looking at older people services. They should be integrated.

Putting people together in the ICAS (Integrated Care and Support Service) unit has made a difference.

Putting people in across the organisations together as a team to deliver the service at local level, as opposed to taking two management structures and putting them in the one building. The two things are different.

Deliver
services
collaboratively
in
localities
for
JW
local
precedence
over
co-ordination

Although, I agree but at the same time I would advocate for what there is to learn from what happens in places like ICAS in terms of how people behave and how they learn together. There's an awful lot of learning out there at the local level that we don't transfer into what we do as managers.... In my mind what has happened in the last decade has been about power and control and about the governance as we see it currently because we go so far along the road and then suddenly take a cautious step back because either 1. There's something going on in the council that is rationalising service delivery or something going on in health in terms of the way we are organising ourselves, that makes us step back. And the GP surgery and Social work are an example of that. They were pushed to centralise the way they deliver and the council also. And it's how we overcome that culture in the new CHCP, because we have been 'nearly there' so many times and stepped back from it. And the H&SC integration has to let us to do that now.

Is it important to record examples and share them as you may not know what's happening in other localities and how you might learn from that?

We tend to judge our success on performance though. A program that went in last year attracted so much cynicism when it started but because it has seen to have been a success in a performance management sense, now everybody kind of is linking into. Its probably not the right way to do it actually. As part of the team, we are continuing to do it and they are all continuing to learn together. But really for me it's about transferring what these folks are learning at the local level into our learning as well as we move forward.

Transfer
many
things
learning
between
at the
locality
level

5. Any suggestions for better understanding and establishing the role, relationships and remit of the collaborative manager in the CHCP?

Its going to be about how we create something new out of a few existing systems. IN the council its done that way and in the NHS its done this way, and which one is going to win. It's actually going to be about how we create a new way.

A new culture. Taking the best from both

Build on the assets of both organisations

But the starting point for that has to be at the highest level

Yes, leading by example and perhaps deciding what parts of the service that could be quick with that, which can naturally come together and could be developed, rather than saying everything has

Its about
bottom up practice,
change
+ learning that
can
drive
the integration
agenda

About taking from both agencies
and creating new ways of doing

to change. So just focusing on the bits where we actually can make a difference and building the strengths.

Start with the ones easier for the organisation to start with services that are easier to approach and learn from it and the process. However it is that you decide to measure that. And then roll it out to different settings.

There will always be parts of the service that have to be separate because they have to be. Integration doesn't mean that they have to be together.

T&C for employment. Would staff always stay on one side or another?

maybe over time, build it over time.

That's one thing you wouldn't want to start with.

We have tried that one, and i've got the scars for that one

it would really need to get political sign up for that.

being
intelligent
the most
change

starting
from
aspect
and context

that are
sharpest and
leaving from
trying

Case A Cognitive Interview Phase 2

What does your role involve

i guess about 60% of the time is taken up by day to day operational work. So thats about making sure there is appropriate governance and management. So that could include meeting with staff, discussing finances with individuals, reporting into the strategic management team about issues, that relate to operations management. I would say about another 20% is set outside that but in a formal way, because i have on behalf of the board, i have leads across a number of different areas including, commissioner for children (child health commissioner), so i lead on childrens services, working across council services as well. I lead on chil protection and community planning. So i would say about 20% is formal structural issues around things outside that operational responsibility. And i guess a further 20% is informal elements of that which is about trying to, outside the forma structure, negotiate with colleagues internal and across the system about elements about collaboration.

- Appropriate Governance + management
- Issues in operations mngt.
- Leading across different services - Horizontal mngt.

What has been your experience with the NHS

Always been with the NHS. I joined teh NHS as a management trainee. I did the institute of Health service management, so exams at that point. So i am a member of the Institute of Health Service Managers. So i trined very early on. And since then its been mainly around personal development. I dont have a clinical background but i have a degree in sociology/ social administration.

- Institute of Health Service Managers
- Steps of training during career.

And do they still have this institute ?

Yes,

Do they tie in with the JIT or NES

ON an informal basis, so often, once a year there is a annual general meeting with the IHSM and they will often have workshops around issues that involve the JIT or NES. Mainly NES Scotland because of the links with education.

- * Level of partnership or coordination between NHS providers

Want to ask you about the CHP itself. Thinking about the different partners and agencies. As you move towards more integration in the future of work towards CHCP status. How would the governance of delivering the service change ?

Well i guess that we are, theres a sort of formal governance and an informal governance. The formal governance will be in the form of legislation which will outline what the essentially what the partnerships agreements will be. Can simply be between NHS and Social work elements of the council. So actually there has to be a change in the legislation in order to allow integrated governance. Thats why if you actually look at the draft bill, it doesnt actually mention integration. It talks about public services working together for the betterment of older people. My understanding is that when the scottish government checked it out with the lawyers, it could not use the word integration because its not a integration of public bodies, its a legal framework which allows the public bodies to work formally together. So then as an example, we would have pooled budgets as opposed to aligned budgets, so its a formal thing, governance. Structure will emerge over the next 18 months.

- Formal / Informal Governance
- * Partnership Agreement as formal governance

Comment [A M1]: Boundaries blurred for 'integration' and can cross ref this with the joint working bill which does not use the word 'integration'.

So a independent or merged legal entity ?

- Emerging Structures
- Pooled Budgets opposed to aligned budgets (form of Governance choice)
- Change in legislation allows integrated governance.
- No legality of integration. (Since bill promotes 'working together' but does not use the term 'integration')
- Not integration of Public Bodies - but a legal framework allowing them to work formally together.
- Legislation or form of Governance.



as purpose / outcome is shared the same

- working / managing operating cross agency inter agency
- But belonging within agency

→ trying to ensure this does not make a difference

- staff management issues resolved through ~~interaction~~ structurally through partnership agreements
- But technical employment issues work!
- Accepting the limitation of partnership working?

- Form of Governance of joint working in steps.

- Steps or Level of preparation for Partnership Agreements

Which is a step further than the existing partnerships, the CHCP's, who have partnership agreements. So those that have that already will find it easier because they will already have many of the mechanisms in place. It will be set in a more legal framework. Outside that is the more informal governance around the community planning and partnership. Of which the integrated partnership will be part.

Would that have challenges of dealing with T&C for employment ?

No, that's why they could not use that work integration. The two models being suggested for integration. One is setting up a single entity, the other is lead responsibilities. So in highlands that's what they have gone for where the council and the NHS has swapped responsibilities in adult services and children services. And in that case, staff in children services are being managed by council and health staff have transferred over employment to a single entity.

If it's a single entity formation, what happens on the staff side of things ? Do staff stay remained as they are.

Yes, and the cabinet secretary gave assurances because I think realistically it was just too difficult.

So, the possibility might be towards one legal entity, so a single formation, but staff being on two separate contracts/tiers

So it will be interesting when you have teams of people working together with different T&C's.

What other challenges do you see with the integration, the structural integration.

I think that the structural integration will, in the past there's been a lot of collaborative working and a lot of it is that will of council leadership or the leadership of the NHS at that particular time. So if you look historically in how they have operated in partnership working, which powers they have been willing to devolve and which they haven't. And structural change makes that more sustainable. I've worked with organisations where we have had integrated teams, I've managed social work services, change in leadership, council change their position and withdraw all social work staff. This makes it more robust and more consistent and more sustainable.

Because there will be a legal agreement, it's binding, and it will be more difficult for any change in political leadership, as an example, because that is the norm. To be able to withdraw from changing.

What about co-terminosity for

We are not co-terminous. There are 3 CHP's in Fife. Fife NHS with Highland Council (?) So when post integration all 3 CHP's will be in it together with the council. So the Board is co-terminous with the council, but the Board is made up of 3 CHP's

From a staff and HR perspective, what are the challenges associated with integration ?

That will be resolved structurally through the partnership framework, so the management issues will be resolved. The technical employment issues won't. So managers will be managing staff in both social work and health, to the same basic procedures but elements will be different regarding employment status. And managers are just going to have to live with that. And the challenge will be that it doesn't make any difference as to who actually employs you, because you're actually working

Partnership Agreements imply a mechanism in place for joint working

outside partnership agreement is informal governance around community planning and partnership

Political Assurances for risks in partnerships

Joint working but with different T&C's

Structural change as by-product of successful collaborative working

Devolving Power (a factor of public history)

Structural change creates sustainability

* Formal Informal Governance to NHS?

Exclusive Co-terminosity post integration

creating the norm through legal agreement with binding changes

together in a integrated way for the same purpose. SO I think the challenge is about leadership. That is freeing up managers to be able to facilitate that journey and not allow the different structures to get in the way.

Good management should avoid that happening, because it should be about common purpose. Because the vast majority of staff have willingness to work. And its how you set up the framework to allow them to work together with as few impediments as possible. They have some example of joint management where we have a senior nurse who manages social work staff and whos accountable in social work. So there are examples where that works. I think its about making sure that we take away the barriers that make life difficult for those trying to manage.

Thinking about building trust and cooperation between managers across agencies, how can that be facilitated do you think ?

I think that, is the crux of the problem. I dont think the problem is going to be about the financial model or the management structure, the issue is going to be dealing with the cultural differences between differetn sets of staff, and there are, althought we have been workign with social work colleagues for some time. When you actually look at how you operate, we operate very differently. And we almost have a different language set. And its not until you start to think about how groups or teams are managed and taken forward, that you realise some of the differences. Its things like, the whole issue of clinical governance and clinical autonomy. How management works, what are accountability is, and the relationshio between officers and politicians, is alien to those of us who work in the public sector. We are accountable to the scottish government. So its an entirely iffrent way of operating that we never really had to dwelve into before but will.

Regards to reporting up, if you think about accountability, i.e. Councils needing to report to counsellors as they are more public facing more regularly than the NHS, seem to be reporting more regularly more heavily on things ?

I would dispute that actually.

You tend to think of it that way, councils because theres counsellors involved seem to be reporting more regularly and more heavily on things. Ofcourse the NHS is public facing. But thinking about accountability, how might it change for the NHS in the CHCP strcutures ? So will you have joint officers in place or joint boards ?

Yes, most boards have already and will have, we have a shadow partnership board, and that will be the crux of the accountability, as part of the legislation. So the single entity will be a partnership board. It will have equal members from the council and the NHS. And we will have responsibility for the partnership. We will have responsibility for establishing and managing this partnership agreement and we'll also have responsibility for agreeing the strategic plan that will inform what the partnership is going to be doing. When you think about it in because of the size of things, we are talking about an organisation that will have responsibility and be worth about 450 million, and it will be a huge chunk of public sector resource. So thats a big issue for So a lot of it will be set in a legislative framework.

So how will that shape out for the three separete CHP's because there is the One Council

we will essentially become one. As part of the new partnership. So at that level, there will be a reorganisation. There will be a significant change. The only jobs as risk are the CHP general managers and the most seniors in social worker, because as a CHP, i cant be a GM of an entity that doesnt exist anymore. Its likely, there will be significant locality structures underneath, so the look

Joint working /
integrated service
journey delivery

Trusts not Rndel

Common Purpose
not Multi Purpose

Barriers in trying
to 'manage'
to Doing

'Crux of the
problem' *

Different ways
of operating

Culture Differences
language sets

Learning by Doing

Comment [A M2]: Policy/framework
for Management Development

Becoming One
Significant Change
and Reorganisation
Risk of Jobs

Reorganisation of
a partnership
of
Significant Locality
structures

of the CHP's might not change, not appear to change that. it will just change at very senior management governance level.

Will that mean co-directors ?

There will be a jointly accountable officer. They will have responsibility for the entire thing. It won't be Co. But there will be co chairs and a co chair of the partnership board which will essentially be a joint governance. But there will be single jointly accountable officer that will be accountable to the chief exec on the board.

The GM at the moment, there is three of them. How will that shape up ?

It will shape up, like any other organisation, with due processes, a new structure will be put in place and we will kind of have to see where we sit (laughs)

In that case, NHS Fife becomes exclusively co terminus with council

yes

would that mean moving towards pooled budgets ?

Yes, at the moment we have aligned budgets we call them, so we have a existing H&SC arrangements that will have a range of services, under partnership agreement around it, they are quite limited. And we see the two budgets, you see it together on the one page but not actually managed together.

Do you see any issues there and how that evolves ?

With the legal arrangements and the partnership agreement will outline how all that will be managed. In a way that will satisfy the legal accounting department of both the board and the council. As I understand it, there is at least 6 working groups at the Scottish government looking at this just in finance. Because there is things like the capital revenue, the way in which money comes into the council and the NHS is quite different. The accountability for money is different. Also, we can't budget or plan quite the same way that council does, because we get our money year on year. At the beginning of the year, the council can set out exactly what its budget is for its services, we can't because we get money coming in through the year. So our position changes through the year. And then, what we can and can't do with that money is difficult.

You mentioned how management has evolved over the years in the NHS. SO if you think about the phase of 70's and 80's when a lot of change occurred, and so as to speak, managerialism kicked in and the market model, had implications for how management was done. The scientific way as as to speak. So of course we are seeing a new era here where your going through integration of services. So do you see a shift away that managerialism ?

I think the managerialism has shifted already because devolution. I came from down south, worked most of my time in England, not really appreciating how devolution had completely changed things, but Management has had to be more collaborative. There's less of that kind of business thrust if you like. But the essence of what we do isn't any different. I think the issue is going to be, that that general management model doesn't sit with the council. In SW, social workers manage social work and there isn't a general management model. So that in itself is going to be interesting and a challenge.

Look to change
Appear to change
'Perceptions of Change'

Level of which
Change is visible

By chance or
unpredictable

Structure emerge
in due process and
senior positions have
to fit in / be situated

Changing Nature
of Principle
of Mngt.

models of
Management

Moving away from the managerialism to think about focusing on the user. Moving towards the CHCP status, what do you think is in it for government and NHS. Is it that services can be improved in their delivery ?

Absolutely. I think its absolutely the best thing for the people that use the service. And if you ask older people in particular, whether they would want to see a social worker and health coming together, they will absolutely say yes. And so this has to be a better way of providing services. Because You will still have gaps and overlaps in what we do, and theres a lack of connectedness for individuals.

I think it is about potentially starting to tackle some of the issues that the commission raised in terms of public sector working together in a collaborative way generally. The christie commission. Which was a very high level, but i think the move towards integration is a way of trying to demonstrate some of that stuff. I think there is a challenge for government because i dont know that they know what to do about some of those questions about the employment status and finance. And i think there is a lot of , it raises questions about the future of health boards, if you take out all the community services from the board, then all youve got left is acute services. So it raises questions about the public sector in general in scotland which i dont think had initially be envisaged. And the restrictions of the way in which health is managed, so it will be interesting.

Coming to co location – i know theres associated advantages with it if you are co located with other partners and agencies, then that can facilitate integration. I want to ask you the challenges and difficulties there might be with co-location between H&SW

I think to be honest with you, the co-location issue is a bit of a red herring. Becasue what is required is the right measure of care and that the staff should be wrapping themselves around, in forming themselves into teams that provide the best care. You can shove people together in a building and it would not necessarily work together unless the collective intent is clear. So ive seen co location that has not worked. And i have seen areas where there is no co location but there is actually a virtual integrated way of working. SO i think thats a wee bit of a red herring. But i think that it is also important symbolically. How people are SEEN to be working together. And then one of the big issues is that again it comes down to what works in councils and over time, or about 10 years we were building health centres in space for SW because SW's were working as part of primary health care teams. In the new regime SW will say, NO No NO, they were centralising our social workers in one building, so they took all the swers out. So, those buildings were designed for that integration which never happened. So i think its important that some of its symbolic.

DO you think there might be a drive for it as you move towards integrated models.

Yes, politicians and managers will want to be able to point at something and say "Look, we have got integrated working"

Specially when it can save money as well ?

Yes, they can do that now in our existing buildings, but perhaps it will increase the pace around how that happens.

To ask you about service innovation ? You tend to think about it coming through restructuring, piloting experimenting new projects and also in how you develop teams and disperse them. How do you see innovation in working with other agencies in partnership in the future.

User Focus a Service Driven

observer levels at which issues can be tackled

Perceives govt-helphlessness in trying to address key questions about employment.

Questions the plausibility of Co-location.

A tool/activity for politicians and managers to provide example with/showcase

Giving a face to integrated working

I think the innovation is largely come through joint planning. Either at a strategic or a operational level. So you'll have groups of staff, or staff that are working on a particular issue, and they decide, they kind of think that " yes, we need to have a different model of care and then we kind of use the different management structures to support that. But then you could have, a good example would be, we are given a strategy around re shaping care for older people. And from that, looking at the model of care, we decided that a model around home service would be, so essentially pull acute services out into the community. So I guess, and then the staff take that on and run with it. So I guess there is not one source. Its about seeing things coming in at different angles, deciding what fits the model and or whether there is a gap in that model that needs to be filled. And then, working them back.

The NHS gives that autonomy at the local level for work to be designed the way you want to be ? SO every board is free to do things as long as they are following legislation or national agenda's ?

Well, I think its not so much. You cant see there is the leeway. But you could say actually "how on earth can local teams find the space for that innovation, when there is all these other things that we have got to do. So one of the things I would challenge you on is the issue about reporting. And the amount of reporting we have to do constantly to the scottish government around the different activities and the different things that are imposed upon us. One of the big issues that we have is that we want to free up our community nursing staff, which are working the new models of care around early years as well as older people. And then they get a circular from the government that we have to immunise every child. Now that will take up all our community nursing resource. And then also there are initiative on breast feeding, smoking cessation, theres all of that all of the time, for which we have to report in depth. So thats the kind of key issue for management, how do you deal with that, how do you protect the clinicians from that. And allow innovation, but at the same time ensuring that they are meeting national expectations.

I want to ask you about managers and their T&D. How do you see the future role of the manager changing and what skills and competences might be needed in the whole integrated CHCP arena

We are going to have to train or develop managers who are able to work in a multi-disciplinary and become more innovative in their approach, as opposed to the traditional management approach.

The interesting thing is that there tends to be quite a senior level in the NHS, you dont come across that wide a environment. And you can be a manager in the NHS and not see any of that other stuff for quite some time, in what your doing. And similarly with the social work staff in particular, they dont have a general management background, so there going to be the need for a common understanding of what is going to be expected of management. Whether its social work or not. And how are we going to make sure that staff have the skills and they are supported in doing that.

Skills and competences might focus around relations ?

Yes, and collaborative leadership approach as opposed to a management model.

You mentioned for example, working with pooled budgets when you integrate into a single entity. What might happen then with training managers as a single entity ?

I dont think there would be that much of an issue with managing pooled budgets as long as there is clarity of the management accounting and the system within which it sits.

Innovation through
joint planning
and multi source

innovation in
joint planning
Re shaping

opportunities
innovation but having to
address nationally

managing in political
context of different sides

Influenced
change in a
complex context.

Developing common
understanding
between H&S

Collaborative
relationship
approach
as opposed to
management models.

Sorry, i referred to how the integration affect the delivery of training or the design of joint training initiatives.

Oh it will completely change. I mean at the moment, we have separate separate training and OR departments. We need to come up with single programs.

What might that entail ? Will it involve joining up OD departments or functions ?

I would hope so to some extent. The difficulty is that you are going to have both organisations will have OD responsibilities outside the partnerships, so in both organisations, there is a separate corporate. So either accessing that resource and bringing it together. Or pulling it out and bringing it into the partnership. I guess that is a discuss to be had.

That integration needs to be there for the T&D function as well if your going to move towards a single formation ? More importantly, its about being able to access that resource from both sides.

I mean, we will need to give that quite a lot of thought because when you consider what the kind of, nurses as an example, will have a fair chunk of the nursing staff for NHS Fife, sitting in the partnership. They will have to continue to have a professional accountability to their director of nursing. Therefore for their own professional issues, there will need to be some balance to make sure that thats being maintained to for their own professional development.

And professional membership is ever increasing. So that professional identity gets stronger.

Yes thats right. I mean in the NHS its perhaps more, we have a history of that. We manage so many different professions already. And lets not even get started working with independent contractors and GP's which is a different kettle of fish entirely. So that is already in place, that is, how all of that is going to work in a different context.

You tend to come across service managers / team managers who have come from a clinical background and they can be complacent about the lack of support or training for when they came into a management role. And they owe it down to experiential on the job learning.

Its something, that we already have to be careful about to make sure that happens and that leadership development is available through the organisation for the professionals that are coming in. I guess thats why general management in the profession came into the NHS because it needed to change so much that actually it required more than the approach that had been taken previously.

As suggested by someone, a way around this might be the government running a PS management training scheme which took on graduates and gave them a rotation of spending time in the public sector agencies for them to get exposure to different services.

I think that is nonsense because management in itself is a profession i would say. A good manager should be able to manage anything. You dont have to know the detail of each element of what it is your service does to be able to take it all and do it all. Its about leadership, understanding, vision and a ability to deliver. Its about everybody having a sense of what their role in management is. Whether your managing one or two people or a whole organisation.

In terms of leadership programs, do you have local initiatives at Fife or do you place them onto national programs/schemes.

Integrating to T&D functions

Challenge of joint OD & MD

Maintain Prof Account.

Borners to improve MD functions

Need for future T&D to develop leaders

Professionalism in mgmt.

We tend to borrow national models and use them locally. For things like Gemmel, Habits of Successful managers. They are borrow and used to some extent. But other than that, we tend to link in with whats going on nationally. A national leadership program for managers, and theres quite a few of those. And theres ones which clinicians can attend. So it varies.

And locally, how are they delivered.

Through our OD function.

Reliance on
National MD
programs and
using them locally.

Annex J

Phase 1 Illustrative Data Evidence

Annex J: Phase 1 Pilot Study - Illustrative Data Evidence

No.	Respondent	Data
Quote 1	R3	<i>We've also got our – an overarching plan for health and social work as well.... that in turn again would support joint work – and there's now obviously going to be a huge integration of health and social work so that will have a large impact on the care that we deliver</i>
Quote 2	R2	<i>One thing I wasn't sure about for this interview, was whether I was a manager because in the sort of very traditional role of a manager, you're managing people, managing money. In my current role I don't do that. I have done that in the past which I found very difficult. But your right, it's much more about projects and working collaboratively with people</i>
Quote 3	R1	<i>Probably in every job that you do you have a supervisor and probably they are one of the biggest stakeholders in terms of L&D and depending on how good they are in their role, they really influence your learning....some of them will give you feedback on how they feel you are managing</i>
Quote 4	R3	<i>Although I would say there are a few managers I've worked for who have contributed quite heavily to my learning as a manager.</i>
Quote 5	R3	<i>Hugely, I mean I think it's only when you start putting some of that theory into practise and it either works for you or it doesn't and you have to find different ways of doing things and some of them just have to be tailored because you're dealing with people and not robots. So yes definitely learning on the job making mistakes, learning from those as you go, changing your approach as you go – yes that has been quite significant</i>
Quote 6	R2	<i>I work with a lot of senior people in the organisation so I get the opportunity to watch other people a lot and try and learn from them. So I've definitely seen people do things well and thought, I should do that..... and if in struggling with something, or think that I will struggle with something then I will usually have a conversation with them ask what they think I should be doing. I do a lot of informal chatting with people</i>
Quote 7	R2	<i>I have a senior colleague in another healthcare organisation who I speak with informally a few times a year in a mentoring role and I discuss with her typically things I am struggling with. Things I finding difficult to solve problems and to reflect on how to do things differently.</i>
Quote 8	R2	<i>Yes, senior colleagues that I work with for example. in this case the medical director. He and I have chatted a number of time about things I would like to do better and partly as a result of that.... I am going forward for this national leadership programme. That was a result of a quite formal conversation.</i>
Quote 9	R1	<i>I was definitely very influenced by people that I worked with so role models and I tried to model myself on them trying to emulate some of their good habits because there was no official training offered. So I think that's the most important influence on my learning.</i>
Quote 10	R1	<i>Everything you learn tends to be on the job as I said from kind of role models or good examples and also learning from mistakes often it tends to make you look at yourself and your own practise and say well if I was in charge, what could</i>

		<i>I have done better, if I was in that situation with a team, how would I manage that situation better</i>
Quote 11	R1	<i>I think mostly its being acquired on the job, depending upon who your supervisor is you may be kind of pushed more to develop it. but I think that's really lacking in terms of clinicians trying to do anything as managers. There's really no framework for developing</i>
Quote 12	R3	<i>..... and as you move into new roles you will never ever be done learning in the NHS, it's just too big. You can never know everything and things change so it is, I have accepted that it is an on-going part of my career in the NHS.</i>
Quote 13	R3	<i>There's always a learning curve , for me of about 6 months before I fell kind of like OK I've got my head round what I'm here to do now and really gotten into the guts of it</i>
Quote 14	R2	<i>I think I would come back to there were probably a few key people that I worked for, who very very much influenced the way I did things and approached things.</i>
Quote 15	R2	<i>I've also gained a lot of that from my stakeholders..... Maybe at an earlier stage in my career having been a minor player in big projects where I've seen other people have to do the planning, influencing, negotiating, so I guess the learning from that is knowledge. I don't know.</i>
Quote 16	R2	<i>It is very difficult to unpick all of this.... I find this all still very difficult – cause I still find defining a lot of these management things quite challenging – but knowledge that's something I gained a lot of the MTS, so for e.g. It's a a much more tangible example things like budget management, or some of the softer stuff influencing skills.</i>
Quote 17	R3	<i>On the job learning – that acquisitional knowledge just continues on doesn't it..... so much of it is just as you go definitely. You can sit and read all the theory you want but unless you have the opportunity to sit and put it into practise then</i>
Quote 18	R3	<i>..... and as you move into new roles you will never ever be done learning in the NHS, it's just too big. You can never know everything and things change so it is, I have accepted that it is an on-going part of my career in the NHS.</i>
Quote 19	R1	<i>I am hoping to take on more of a administrative role. I think there's huge scope for managers who are dual trained. Who have the clinical background but whom also have the business knowledge, so I would like to work in a strategic role ideally on a trust level or above".</i>
Quote 20	R2	<i>Well I guess partly what I want to do I don't know – it would be partly what I want to do – partly availability of roles – you'll be aware of the financial situation at the moment which means there aren't loads of jobs around. It's a huge difference. I've been in this job for about 3 years - and it's a very different context to when I started – a very very different context. So you know there aren't many jobs that would come up which one would even think about applying for.</i>
Quote 21	R3	<i>And not only from a personal point of view but actually the landscape of the NHS is changing AGAIN, and you know there just aren't the promoted posts to make that career progression as it used to be – so this kind of grade of post I'm in currently, is like gold dust – they just don't exist now – and that even more true of</i>

		<p>the grade above and of the grade above and so on. So it makes it very difficult to carve out – there's no neat path, it's very difficult to predict. And so many jobs are now temporary or fixed contracts, again that doesn't appeal to me..... I can't necessarily make decision based on a temporary contract anymore. (ON COLLABORATION AND JOINT PARTNERSHIPS) Yep and that will make it even less managerial roles I would have thought because they will just join things together so.</p>
Quote 22	R1	<p>I think there's gona be a lot of changes. The idea that there are clinicians and there are managers, that kind of illusion is gona be shattered, doctors have to be willing to accept the fact that they do work as managers and try and work with administrative staff of the NHS a lot more. I think theres very much a them and us mentality. And I think that does not work. I think clinicians are going to be forced to interact a lot more, which will be a good thing".</p> <p>.... its going to change – doctors have to realise that they need to act as managers to try and influence whats happening around them. They need to work with people in management to try and make things better for everyone rather than getting angry and disengaging and becoming disenfranchised. I think it has to be more integrated".</p>
Quote 23	R2	<p>Oh I think ye s- it will only become more difficult – I think the financial situation has already made it more challenging – so more difficult decisions to be made – more kind of bad news to give to people – So when I first started training as a PH doctor a lot of money was coming into the NHS and we use to do what were called resource allocation exercises – there was a new pot of money coming in, how would we spend it, and now we are exercising to put things down. There not nice conversations to have with people. The sets of emotions and behaviours that are involved are very very different to when its – you there – here's some money guys – what should we spend it on – so its very different-sets of conversations – and the – there's all sorts of things colliding – there's less money, we are trying to relentlessly improve the quality of what we do, the patient and public expectation continues to increase – and all of these things make you feel like its all tough.</p>
Quote 24	R3	<p>I think the integration of health and social care will make a huge impact on that so, I think a lot of roles in the future will no longer be considered with just health services and you know partnership working with will be jointly managing joint teams of health and social care staff. I think that will mean less of these roles.....</p> <p>In relation to tasks, they will pretty much stay the same as well I think – it'll be about staff governance, financial governance you know, value for money..... I think part of the health and social integration is the hope that we will be able to pool resources and work more efficiently as one big unit –</p> <p>Yes we are anyway – I don't see that getting any better. I don't know if that will get any worse. Probably (laughs), But yes that won't go anywhere. We will constantly find our hands tied with no money.</p>
Quote 25	R2	<p>But I understand they (REFERING TO PARTNERSHIPS) pose some interesting challenges cause your taking people from different organisations with perhaps different org agenda's – even different ways of communicating – different ways of recording data – the whole stuff like that – but these are all important things if you're trying to bring two groups of people together.</p>

Quote 26	R2	<i>I think there's a huge thing about resilience as well – resilience with the capital R will be needed in the coming years because I think – we feel that things are difficult now but I think they are going to feel even more difficult in 5 years' time. people leave now, they retire or go on whatever – no one's replaced - there's fewer people – we will all have more work to do as it were. For me will it be working with different stakeholders – probably – I mean because a lot of my work is very inside the health board, it may not stay that, depending on what how my job changes with the integration of health and social care services, I may well spend more of my time working with people in the local authority which I haven't done in the last few years in my current role.</i>
Quote 27	R3	<i>I think in the NHS certainly in the last few years since agenda for change for this kind of level its very much about masters level or equivalent – and I think that won't change and that will stay the same – that you'll need that level of education and knowledge in order to do the job I mean just before you arrived that was someone had asked me to – nothing in relation to my role – but I'm an independent person with a clinical background and could you please review these services and write an independent report for me in a month – with the stats – and it's OK yea that's fine – you know, so more and more your kind of expected to absorb bits and pieces of work – and fit them in which is fine but something's got to give at some point.</i>
Quote 28	R2	<i>There's some pretty big things on the NHS Scotland horizon as well – like the integration of health and social care services is kind of imminent – so that feels like it will be quite a difficult thing to navigate..... I think that's the only way it will work (integration) – whether or not we will do that instantly I don't know – particularly on the health and social care side of things – you these are very – people have very different ways of working and to try and merge those integrate those is going to be certainly interesting</i>
Quote 29	R1	<i>At the moment – managing is not formally evaluated..... If there were no problems highlighted, it would be assumed that I was doing that part of my job.</i>
Quote 30	R2	<i>Well its supposed to be for us but it isn't – we are supposed to have an appraisal which is supposed to be very much about our professional competence and maintaining our professional standards..... . But my experience is that the performance review and the appraisal get quite muddled up I think. I think the process should be a learner orientated process – when I think one should reflect on what they have achieved in the year – and where one still needs to go – but I wouldn't say that it is in reality. More so it is performance focused. I can see why its hard to do, because actually to demonstrate that im maintaining my professional competence you need to refer to things you have achieved during the year.</i>
Quote 31	R3	<i>There's room for both I would say – and I would like to think that certainly the appraisals the reviews I carry out with staff are very much about a bit of both. You know how they have developed over the year personally and how they have contributed to the service or the organisation so I try and very much make that about both – and their PDP is very much a bit about their own personal development but their own contribution to the service as well.</i>
Quote 32	R3	<i>I have done a 360 but it was part of the scheme. But it's not something regularly employed. There's quite a cost attached to 360's so they tend not to be done unless they are part of some leadership programme..... but it's not something that's run at the mill because there's a cost attached to it.</i>

		<p><i>I think it's actually a really really good thing – sometimes you don't always hear what you want to hear from it but in terms of telling you things perhaps you need to develop in or highlighting any areas for you. Then actually I think it's a good thing. It may be hard to hear it sometimes but - and they would value it (THE GIVEN STAKEHOLDER OR PARTNER)..... I think 360 is a really good way of doing things it's just not the norm.</i></p>
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Annex K

Phases 2, 3 and 4 Data with accompanying commentary

ANNEX K: KEY DATA FROM THE INITIAL ANALYSIS, WITH COMMENTARY

This Annex presents the equivalent of the Initial Tables of Data that are found in studies that follow a quantitative paradigm. Its purpose is to show the “workings” on which the In-Case and Cross-Case Analysis set out in Chapter 6 are based.

The Annex presents each of the four cases in turn, with the material organised according to the five themes and in sections that deal with the outcomes from, respectively, Phases 2, 3 and 4.

PHASE 2: THE INTERVIEWS

CASE A

Theme 1: Perceptions of Change in Joint-Working and Integration

Health and Social care service integration at the CHP level is treated as a non-structuralist agenda but at the same time there is acknowledgement that legislation seeks structural change. Despite have a history of joint working in partnership (informally governed), legislation will now outline formal partnership agreements that take existing partnership to a newer level to provide formal governance. At present, it is unclear as to what structure the future CHCP embraces

All-1: We don't in Case A see it as a structuralist agenda... We are trying to promote it as a cultural agenda. Taking an assets based approach..... Because CHP's we know will go, and they will be replaced by community health and social care partnerships, and we are not sure what they as organisations totally look like (R1, Head of OD)

All-2: We have said that we are not promoting a structuralist agenda...But then we have to get rid of CHP's and merge them into new entity. So the idea that there will be no structural change is disingenuous (R1, Head of OD)

All-3: Well i guess that we are, there's a sort of formal governance and an informal governance. The formal governance will be in the form of legislation which will outline what the essentially what the partnerships agreements will be..... So actually there has to be a change in the legislation in order to allow integrated governance.....Structure will emerge over the next 18 months.... So then as an example, we would have pooled budgets as opposed to aligned budgets.... I dont think there would be that much of an issue with managing pooled budgets as long as there is clarity of the managent accounting and the system within which it sits (R2, CHP General Manager)

All-4: I guess everybody is waiting on is what the guidance from the government has to say (R4, CHP Localities Manager)

Hence, managers show confidence in working jointly across agencies as a routine practise and distinguish this from the forthcoming legislative changes that will provide formal governance to the integration process of H&SC.

Health and social care integration is viewed as the provision of a legal framework where by agencies can come together formally to deliver joint services. This is a step further because formal partnership agreements come into place. CASE A nevertheless considers itself to have taken a pro-active approach to preparing for change by appointing a joint shadow board and an interim joint director for health and social care integration.

All-5: That's why if you actually look at the draft bill, it doesn't actually mention integration. It talks about public services working together for the betterment of older people. My understanding is that when the Scottish government checked it out with the lawyers, it could not use the word integration because it's not an integration of public bodies, it's a legal framework which allows the public bodies to work formally together. (R2, CHP General Manager)

All-6: ... we have established at the level of the board members and senior councillors, a H&SC partnership board....and the job of the shadow board and the interim director is over the next 18 months to get our system into a state of preparedness, of when the legislation is enacted in a year or 18 months' time, that within CASE A, we are well prepared to implement the new legislative framework that we will be operating within.....at the strategic level, we have the shadow board which brings together senior counsellors and board members to oversee the process of change and we have got the interim director in post. And i think...within Scotland, we have made quite an early appointment. (R1, Head of OD)

The upcoming legislative changes that encourage integration in the form of partnership agreements are welcomed as encouraging devolved powers and making joint working more robust, even though it is acknowledged that particulars of the change process are unknown.

All-7: Oh yes, I'm sure the integration model is the way forward... (R3, Head of Physio Services)

All-8: So if you look historically in how they have operated in partnership working...structural change makes that more sustainable....this makes it more robust and more consistent and more sustainable...because there will be a legal agreement, its binding, and it will be more difficult for any change in political leadership...to be able to withdraw from changing. (R2, CHP General Manager)

All-9: I guess that (integration) is a personal opinion at this point because we don't really know how that is going to happen. I guess to some extent that depends on the structures that are put in place to support that integration agenda. But I think it's clear to me that things will change and I think there needs to be (R4, CHP Localities Manager)

A pro-active approach to preparing for future integration is evident. Structural integration as encouraged by the joint working bill is welcomed and seen to be an enabler of improved joint working.

Despite the integration agenda being embraced, the transferability of success from one context to another is contested and the change process is seen as difficult given the current pressures of service demand and austerity.

All-10: ... the theory is that by integrating we can work smarter and better. But i don't think, im not aware of any great evidence base that suggests that that's the case....So i think money is the real issue in the future, and the hope is by working effectively together, we will get more bangs for our bucks....And people keep citing examples like Torbay. But whether the transferability of that success to different contexts i think is an issue and time will tell. Because its clearly the government believes that's the way we have to go, we have to be more integrated in our ways of working. I think people generally accept that at an intuitive level (R1, Head of OD)

All-11: I am sure if you have looked at many papers on integration, they are not particularly encouraging. So this legislation is quite vague in many ways as to how we make this work (R3, Head of Physio Services)

It is evident here that while integration is accepted as being the way forward to address challenges, its implementation and transferability across contexts is questioned by managers who have to manage the change process.

Theme 2: Managing With Complexity and Ambiguity

There is concern about different T&C's of employment for staff between agencies which will create challenges. There is a realisation that even where staff management issues can be improved through partnership agreements over time by the CHCP, the technical employment issues however cannot be. This is observed as a limitation of collaborative integrated service delivery. To overcome this, a corporate body model for the future CHCP is envisioned over a lead agency model.

All-12: So managers will be managing staff in both social work and health to the same basic procedures but elements will be different regarding employment status. And managers are just going to have to live with that. And the challenge will be that it doesn't make any difference as to who actually employs you, because you're actually working together in an integrated way for the same purpose (R2, CHP General Manager)

All-13: My understanding is that we are going to retain these T&C's but then what happens for the people working in the same offices or very closely or end up doing similar roles but have different pay and holidays etc. (R4, CHP Localities Manager)

All-14: Yes, so I think terms and conditions, which are very different...so if we are coming together at different pay scales that is obviously going to be a problem (R3, Head of Physio Services)

All-15: The two models being suggested for integration. One is setting up a single entity, the other is lead responsibilities..... and the cabinet secretary gave assurances because I think realistically it was just too difficult..... T&C's (R2, CHP General Manager)

T&C's for staff are seen to cause complexity in the integration process and influences the integration model adopted in the future.

Change as forthcoming is viewed as politically driven and different political agendas between agencies at the executive level are seen to cause complexity and ambiguity.

All-16: It would be the political agenda. Usually more minor changes are locally driven but usually it comes from the top and then I guess we have to locally decide what we have to do within the framework we are given, which always turns out to be very difficult (R4, CHP Localities Manager)

All-17: I think right now the agendas are different with different masters and for front line staff that doesn't necessarily facilitate joined up service for patients. Indeed it may hinder it (R4, CHP Localities Manager)

Due to different political agendas, it makes it difficult and complex to adopt a joint service framework at the local level to deliver integrated services.

Being in joint management posts, working with two different sets of policies, reporting up two different streams and funding pressures all create complexity.

All-18: We tend to work with our own separate policies...But they are issues that are not easy to resolve.... it would be better to be reporting in one place... I guess we are not really clear on how that might look (R4, CHP Localities Manager)

All-19: The first thing you need to do is get the same paperwork for the integrated service. Because you will have a variety of paperwork and everybody is very precious about their paperwork. But you need to come up with documentation that's a single document for a single service (R3, Head of Physio Services)

All-20: It just seems that no matter how well our services are managed or how efficient they are, and how well we are integrated, there is still a funding challenge (R1, Head of OD)

At the operational level, these complexities remain a challenge in managing future integrated service delivery.

Cultural differences between agencies and different ways of working are seen as complexities because they affect trust and cooperation building.

All-21: I think that, is the crux of the problem (referring to trust and cooperation between managers across agencies)....The issue is going to be dealing with the cultural differences...When you actually look at how you operate, we operate very differently (R2, CHP General Manager)

All-22: I think when people are feeling vulnerable about restructuring, they tend to revert to their professional groupings. With the integration agenda that will be even more pronounced. To be honest I don't understand their culture and if I'm honest I don't know entirely what they do... (R4, CHP Localities Manager)

All-23: Thinking about governing the network of H&SC partnerships, who sets out the rules and procedures and who the different managers from both agencies will be reporting to? (R3 Head of Physio Services)

The findings reveal that these differences in cultures and ways of working between agencies create ambiguity for ways in which the future partnership and management

processes will be governed. They also cause managers to resist change and new ways of working.

The purpose of having an OD function is to facilitate and support managers through change. However, it is recognised that the OD functions of both health and council agencies will have separate responsibilities.

All-24: we are interested in developing a strategic approach to learning in our organisation.... I also have a small but beautifully formed team of OD consultants and their job is essentially to support managers and senior clinicians and staff who are engaged in the process of change (R1, Head of OD)

All-25: The difficulty is that you are going to have both organisations will have OD responsibilities outside the partnerships...So either accessing that resource and bringing it together. Or pulling it out and bringing it into the partnership. I guess that is a discuss to be had (R2, CHP General Manager)

The OD functions of both agencies are seen to support managers through change and complexity however, don't engage in any collaborative form for the integration agenda.

Theme 3: Service Logic and Value Creation

A paradigm shift is advocated where achieving and measuring outcomes is not just through systems and processes, but also through people and quality. It is where the focus is "on the journey not the destination and on the process not the product". Such a shift however is a challenge given the inclination towards rationalistic management thinking and practice and culture of measurement which prevail at senior executive levels.

All-26: My theory is...NPM came in, the old beverage Keynesian consensus was dropped, Mrs Thatcher came in, neoliberalism triumphed, these guys have been in there jobs in that period of time, they've been groomed in the 70,80,90's.... So they have got to the top of their greasy pole but through the deployment of rational managerialism but that is also perpetuated at the political level because politicians don't like complexity. For every complex problem there is a simple solution which is wrong. And they will want us to demonstrate, that because we are integrated. We are therefore more successful....Because it's the only idea we have I think. I don't see any other great idea..... So simple problems are problems that rational managerialism can handle. Wicked problems are, because we are working in a whole system, what happens over here..... So, it maybe that if we can define a simple problem and manage it rationally, because that's a good way of managing it, but we also recognise that the environment in which we are operating is hugely complex and interdependent and you know, in constant flux, in a constant state of becoming, then we need to deploy different approaches which are less controlling, less directive, less top down, which are much more about creating this environment where people can innovate, take risks....Do our organisations given the political environment have that appetite for risk, or will they simply fall back on what they believe is tried and tested. So the managers that have got to the top of the greasy pole, their probably beyond redemption, and there's a part of me that thinks all good revolutions start from the bottom. And so maybe we should be focusing on the next generation of managers in a developmental sense rather than the existing, because they will move on, they will eventually leave (R1, Head of OD)

All-27: I think Scottish policy is very much around how agencies can work better for the patients. I also think though sometimes... that can be driven by individuals and their own beliefs and values which sometimes may not be to the ultimate benefit. (R4, CHP Localities Manager)

All-28: ...there's a definite tendency in an audit culture or audit society to measure things we can't measure. Outcomes, we are emphasizing outcomes in commissioning in xxxx at the moment. So we want an outcomes driven approach. And in a sense how you achieve those outcomes is a management challenge. But often we distil that management challenge into a bureaucratic and rationalistic approach, so we develop systems and processes that will hopefully help us achieve the outcomes. And again, nothing wrong with systems and processes, but we all need to do due attention and due diligence around culture and people....treating patients is so complex and everyone's different.... you still need to recognise that you can't distil everything down into quantifiable outputs. We have a strong quality agenda, and I think the quality agenda is the sensible agenda to pursue, because everyone will agree we should provide the best service we can. Everyone wants to do the best job they can. I'm still to meet a person that doesn't want to do a good job....But when we get into an organisational context ... and the so called improvement sciences is what we apply in the NHS to improve quality, so that takes you down the route of ever more measurement to try and demonstrate to whom so ever that our services are of a high quality (R1, Head of OD)

All-29: They have no regard to the values, the context, the culture and it's just the market will do the rest. And it's really worrying. And the other thing I know about new public management is that there's no evidence base for it.... All the measurement work that's been done suggests it's regressive (referring to NPM). But there's something in us that likes it. And I think it's something to do with simplicity. The management consultant coming along and saying.... You know it sounds more authoritative 'you have to be leaner' (R1, Head of OD)

There is evidence of strong sentiment about management ideology, management practices and what constitutes service value in the NHS. A strong tendency for rational management and measurable performance in the NHS is reported. NPM practices are reported as being prevalent because they offer simplicity and sidestep complexity. Managers' report value creation as taking into account the importance of users, people and culture.

Service managers' suggest that management practice has shifted with now the case that management models and restructuring carry lesser relevance as public services increasingly become driven by user focus. There is also the significance of individuals and teams at the local level that enable this shift but nevertheless are challenged by national performance expectations

All-30: I think service innovation actually mostly occurs despite structures and restructures and not because of it. I think it's very often driven by individuals or teams of individuals that are themselves highly motivated to provide better care... I think smaller changes at the everyday level can happen very easily....Certainly in CASE A I think it's actually driven by individuals or their close teams. (R4, CHP Localities Manager)

All-31: I think managerialism has shifted already because of devolution.....i think it's absolutely the best thing for the people who use the service. And if you ask older people in particular whether they would want to see a social worker and health coming together, they will absolutely say yes. And so this has to be a better way of providing services (R2, CHP General Manager)

All-32: We could become a victim of change in that everything is changing, and you lose the whole point of what you're about. Which is about providing care for the patient. So for me innovative care has to come from the patientHas anybody asked what the patients want? So it's about what is it that the public want? And then what to my stakeholders want?...Innovative change for me is where there is quite a dynamic parental shift really, it's that shift out (R3, Head of Physio Services)

All-33: If we are providing services around the needs of the individual, the individual really doesn't care who the services are coming from. Providing they get the services at the point of time that they need them....people on the ground, so our staff in health and staff working for the council, do make links and work effectively together because it makes sense. People in the front line get it because it probably makes sense for them to be interacting, and exchanging information about the needs of the client or the patient they are looking after (R1, Head of OD)

All-34: We should change structures where it makes sense and form should follow function by and large....I think people confuse structural change with progress...it's highly debilitating, takes your eye off the ball of delivery and providing good quality services....In health people are very sceptical about structural change now...They don't believe structural change will provide any real benefit.... (R1, Head of OD)

A shift in management practices to suit purpose is reported by managers: there is lesser relevance of management models and structures and more an influence of users in driving change.

Theme 4: The Managerial Remit: Roles, Responsibilities and Relationships

Becoming politically informed about changes and keeping abreast of developments across services are considered an important aspect of the managerial remit

All-35: How management works, what our accountability is, and the relationship between officers and politicians, is alien to those of us who work in the public sector...So it's an entirely different way of operating that we never really had to delve into before but will (R2, CHP General Manager)

All-36: You have to be very clear about what you're accountable for. So I think from the point of view of managers and staff, we have to clear of what our role and remit is and we have to understand the role and remits of others we are working with, particularly from other organisations and also how their systems of work go (R3, Head of Physio Services)

All-37: And you can be a manager in the NHS and not see any of that other stuff for quite some time, in what you're doing. And similarly with the social work staff in particular, they don't have a general management background, so they're going to be the need for a common understanding of what is going to be expected of management... (R2, CHP General Manager)

All-38: If you're not pulling the political agenda...you are not going to succeed....To have the ability to look at the wider picture and to follow that care group right through from beginning to end and back again (R3, Head of Physio Services)

Managers will need to understand different inter-agency accountabilities and relationships, understand different systems, try to gain clarity of their role purpose, keep up to date with political and policy changes, develop a common

understanding of the larger system in which their agency and service fits and understand how that has an effect on the integrated service delivered to the user.

The scope of managerial roles, responsibilities and relationships is expected to widen as services and their staff integrate. Within such an environment, it remains important to uphold the focus on service purpose while addressing resource limitations

All-39: ...we are asking line managers to do that networking. And they are not use to discussing that...But now they are going to bring in more stakeholders and come to a more democratic decision making model. And some of them find that quite difficult because it slows things down initially (R3, Head of Physio Services)

All-40: You have to keep focus on the patient all the time and not just on what you want for your career pathway...This is not about your personal goals, it's about the care group that you manage and how are you going to get the best for that service delivery (R3, Head of Physio Services)

All-41: But I do think that the managerial role is getting tougher, especially as resources are reducing, so you really have to know your job (R3, Head of Physio Services)

All-42: Integration needs managers who are willing to listen and to understand the whole picture as opposed to the picture they are familiar with (R4, CHP Localities Manager)

The evidence suggests that the managerial remit will widen beyond the single agency and become complex as there will be a need to engage with a wider circle of stakeholders; engage with more democratic decision making and doing things different to before. It will also be important in the midst of this to maintain a focus on service purpose. The managerial role is perceived to get tougher with the diminishing of resources.

Theme 5: The Learning, Training and Development Of Service Managers

In order to manage in an integrated environment that involves multi-disciplinary teams, managers will need to be trained and developed to go beyond the existing scope of work and develop relationships while not getting fixated on the need know all aspects of services.

All-43: We are gona have to train or develop managers...to work beyond their actual accountability and become more influencers of change in a complex environment. (R2, CHP General Manager)

All-44: You have to gain the respect of the people you manage in multi-disciplinary teams.... some of the managers have been here longer than me so there is a kind of, people know each other and it's about relationships... (R4, CHP Localities Manager)

All-45: A good manager should be able to manage anything. You don't have to know the detail of each element of what it is your service does to be able to take it all and do it all. It's about leadership, understanding, vision and an ability to deliver.... (R2, CHP General Manager)

These findings suggest the need to train and develop managers to be able to deliver, to lead and build relationships, be diverse and resilient.

In relation to clinicians coming into managerial roles for integrated service delivery, managers suggest that this needs to be carefully addressed through appropriate succession planning and developing leadership ability for the new service environment.

AII-47: There's something about training clinical professionals going into management roles. I think succession planning is going to be very important. I can see there are a lot of managers over 50 so you multiply that across the area retiring in the next few years. And I guess it's about training the level below. That's training needs to incorporate the different skills for collaborating and integrating (R4, CHP Localities Manager)

AII-48: It's something that we already have to be careful about to make sure that happens and that leadership development is available through the organisation for the professionals that are coming in (R2, CHP General Manager)

AII-49: if we are talking about a senior management system and dealing with social services and education and so on, i think that has to come up a level. It's a different breed and there is a need to get there faster. (R3, Head of Physio Services)

The evidence suggests a need to pay more attention to the T&D of individuals transitioning into management roles and developing a strategy to do so.

A supportive and relational approach to developing leadership in managers is advocated. The need to develop jointly-produced training and development is also highlighted.

AII-50: ...a collaborative leadership approach as opposed to a management model....at the moment, we have separate training and departments. We need to come up with single programs (R2, CHP General Manager)

AII-51: What we are trying to do is very complex, so a different leadership style or a different leadership approach, is required that is suited to work successfully in that complex environment, because rational managerialism won't achieve the end point we are looking for. (R1, Head of OD)

There is an inclination towards developing collaborative leadership and to provide support and enablement. The evidence also suggests that MD needs to be co-produced between agencies.

CASE B

Theme 1: Perceptions Of Change In Joint-Working And Integration

Whilst managers are committed to service integration, achieving this is done using existing organisational set-up with the belief that structural integration is not a pre-requisite for successful joint service delivery

BII-1: Whatever structure you end up with.... you can still provide integrated children services without changing the management structure. . We have been trying to do that with services for 10 years and we have never had joint management arrangements with education (R5, Head of Specialist Children Services)

BII-2: But after finishing with the integration we have held onto working as partners and keep those relations going.....we have done more since we divorced (referring to the separation from partnership), we've managed to progress more and we are more clear as to what our boundaries are. So we still work together really well, but we can actually proceed and pus tings through our separate systems quicker. (R6, Head of Primary Care and Community Services)

BII-3: One of the challenges around change seems to usually involve some kind of re-structuring...Which means people are in a constant state of not knowing what's happening... Energy goes into the decision and not very much goes into making it happen (R7, Head of Organisational Development)

The agenda for integration is treated as a separate agenda to existing joint working set up that prevails in Case B. Structural changes are strongly associated with integration and in light of previous experiences of H&SC integration, difficulties and problems are highlighted with such a change.

In order to improve joint working between agency staff and to make integration work, there was a need to implicitly improve manager's knowledge about; and their ability to deal with; agency differences that are primarily cultural, operational and political

BII-4: Challenges in being integrated are about being clear about what the shared vision is. I don't get a sense that social work staff are allowed to be as innovate as health staff. And I think it is because social work is very very, they are not empowered to make decisions. They have got to ask and ask. So its very very hierarchical and people are not empowered to make decision at the local level, in fact I would say that they are actively advised not to do that. Whereas in the NHS we are able to go out there and think differently and do things differently.... They work with a different perception of risk all the time. What they work is risk all the time and what we work is risk some of the time (R6, Head of Primary Care and Community Services)

BII-5: I think they think they are more accountable (referring to Social Care)Our political legitimacy in the NHS is quite distant. (R5, Head of Specialist Children Services)

A clear sense of the difference between agencies are identifiable by managers. Forthcoming legislative changes for the integration agenda are not embraced. Largely, the problems and difficulties of attempting health and social care integration are highlighted. Pro-activeness or preparation towards future integration is not evidenced.

Theme 2: Managing With Complexity and Ambiguity

Managers refer a great deal to ambiguity in roles, structures, terms and conditions of employment and employment security during change periods and in attempts to integrate. They point out from past experience of operating as an integrated set-up the difficulty having to work with two different sets of policies and being unclear about roles.

BII-6: The fact that it is so context specific for people and at the moment there's a time of uncertainty because they (managers) don't know where they are going to be and who their leaders are going to be and that is disconcerting in some ways (R7, Head of OD)

BII-7: We were having to work with two different sets of policies and you lacked managerial clout (R6, Head of Primary Care and Community Services)

BII-8: When we come to an election.... because the NHS is one of the things that wins votes. And by nature of that, we end of with some kind of re structure. That is not helpful because you're perhaps creating some disparity, you've changed something I think it creates quite a lot of frustration. And sometimes fear in people because they don't want to re structure that often (R9, Locality Children's Services Manager)

BII-9: We were very negative about the other staff, about the experience they had had in the structure. And I think that some of that was about people weren't particularly clear about their role.... (R9, Locality Children's Services Manager)

BII-10: I think it's that they (managers) felt threatened, I think the differentiator of their health role was they their parameters were not clear enough and therefore they felt they, or their roles were perhaps going to be consumed. That they were going to be asked to do something out of the parameter of their job (R9, Locality Children's Services Manager)

Lack of clarity about integration processes, restructuring, terms and conditions of employment, lack of clarity in roles, duplication of effort in terms of dealing with two different sets of policies and reporting structures are identified as complexities and ambiguities associated with change. Managers view these ambiguities of integrated working as problematic going into the future.

Theme 3: Service Logic and Value Creation

Managers exhibit a strong sense of delivering user focused services while taking local context into consideration. They are of the view that service re-design (i.e. integration) that intends for process and outcome change must be based around

the user. That is, understanding service needs according to the user first and then working backwards to structure the service accordingly.

BII-11: If government restructured tomorrow, the NHS Board re-structured tomorrow...the patient you see will still be the same. (R9, Locality Children's Services Manager)

BII-12: Rather than structural change, it is creating cultural change. I think you could allow form to fill a function. It is the function that we expect all middle managers in children services regardless of who you work for to always be able to evidence their decisions on the basis of integrated children outcomes...(R5, Head of Specialist Children Services)

BII-13: Put 10 clinicians in a room and ask them for an outcome and you will get 9 processes and maybe 1 outcome. And that 1 outcome may not be described in a way that a child would understand it. So I am talking about functional outcomes in mental health services. It is to define these outcomes with parents, children, families and take them and work backwards (R5, Head of Specialist Children Services)

BII-14: ... we certainly involve all the trade unions. So why wouldn't you do it with service users. You either see them as a partner or you don't see them as a partner. If they are a partner, then they should be involved in the services. (R10, HR Director)

A commitment to users and delivering outcome focused services is evident. Value creation is associated with designing and delivering user focused services and managers show a clear sense of purpose in this regard: that is form follows function.

Theme 4: The Managerial Remit: Roles, Responsibilities and Relationships

Managing in integrated services will be about understanding the reasons for why agencies link with each other and managers will need to go through a learning curve. Successful joint working will depend upon managers making the transition from single organisation management (to which they are accustomed in terms of the scope of their role and responsibilities) to operating and managing in inter-agency networks where multiple relationships must be managed. Managers will have to be willing to learn the new organisation (made up of inter-networked agencies) and learn different governances and cultures while developing the will to operate beyond their agency boundaries. Managers indicate the need to understand and learn about the larger political agenda and the increasing inter-dependence of agencies.

BII-15: I think you'll need very good influencing skills. Influencing partners, keeping them on board. Having very good listening skills. You have to be able to do appreciative enquiry.... you have to know how you dig down and find what the real issue is and try and flash that out. That's the kind of challenge when you work with different partners. I think you have to be tenacious (R6, Head of Primary Care and Community Services)

BII-16: Different organisations have their own culture and different ways of doing things. And you've got to learn that and work with it...we need to work with other cultures and

accept them... you have got to actually take the time and effort to learn the culture and work with it. So patience and listening are absolutely crucial (R8, Head of HR)

BII-17: The challenge is about learning a new organisation and learning new governance structures, the parameters within it, but that is not insurmountable..... (R9, Locality Children's Services Manager)

BII-18: What will be key is understanding what influence is really about. I think developing relationships, being able to engage with and being able to motivate different groups with different needs. And it will be much more around using information to inform what it is that you need to do and the decision you need to make. (R7, Head of OD)

BII-19: If you have not worked in an integrated structure before, then it's a challenge...How to use multiple systems and being more flexible (R6, Head of Primary Care and Community Services)

Managerial remit will need to engage in a multitude of skills and behaviours as found above. These findings are analysed in Chapter 6 of the thesis.

Theme 5: The Learning, Training and Development Of Service Managers

Managers suggest the need to be adaptive, step out of comfort zones make use of existing managerial skills. The challenge for managers identified is that of leading multi-disciplinary teams where managerial authority and knowledge are challenged.

BII-20: I always think of it as my toolkit....You have to be very adaptable and change to different styles. You have to bring different tools into play....Look at your skills and move out of your comfort zone.... Work in an area you know nothing about. Because that's when you really find out how much your skills and tools are transferable and where the gaps are (R6, Head of Primary Care and Community Services)

BII-21: I think if you're working at a manager's level and if you have an open outlook, you're willing to change, willing to go into joint structures, the skills and competences you have should take you with them. It's absolutely about being willing and motivated and having the vision to do it. I don't know that you need a new bag of or if there are a new bag of magic skills, because if there are, I'd like to have them now ((R9, Locality Children's Services Manager)

The evidence suggests being able to lead on the basis of relationships. Existing skills are identified as being transferable and behaviours are identified.

Managers also encourage the developing of relational leadership ability as being important rather than hierarchic leadership

BII-22: There are multiple layers of leadership. Leadership is a way of operating rather than just a hierarchical entity so as to speak. You need to have strong leadership from the top but you also need leaders at different levels that can translate at those levels and lead at different components. Otherwise the whole doesn't work. (R8, Head of HR)

BII-23: A lot of people think leadership only comes with a supervisory role as opposed to a much more virtual or relational basis where yes you feel that you do lead. (R10, HR Director)

The need to develop relational leadership capability is identified in contrast to traditional hierarchic leadership capability

A lack of support and opportunity for management and leadership training is identified. There is a recognition that generic and formal T&D approaches do not service the needs of middle managers to succeed with integrated services. A move towards Action Learning Sets for MD are supported by managers even though not yet modelled or practiced.

BII-24: People who get the least development would be service managers, because the way it works is either leadership development for senior people nationally or locally, or for the front line and just above. Service managers are that squeezed middle group. They don't have huge amount of time for development work. They just don't have the opportunities (R7, Head of OD)

BII-25: The fact that it is so context specific for people.... it would be helpful to have some models that are thought through or are just have even a starting point.....If managers can have a model to identify the structure or the change process and connect it to their own T&D needs...there would be a lot of learning in that in itself. (R7, Head of OD)

BII-26: Sometimes within the NHS we feel that we need to train everybody, and everybody needs the same skill set. That's not actually true....it's not just about putting training courses on, it's about staff readiness to engage (R8, Head of HR)

BII-27: Action learning is a possibility....We are trying to support it more through the SSSE has given us some support to train people up with action learning set facilitators with the aim for supporting integration... (R7, Head of OD)

The findings reveal a lack of T&D opportunities for managers. Formal T&D programmes are seen as non-useful to deal with the contextual issues of service integration while action learning is advocated.

CASE C

Theme 1: Perceptions of Change In Joint-Working And Integration

Managers in CASE C are already engaged with a CHCP set up and based on their experience of being structurally integrated, are positive about future changes and embrace the challenges of integration. All service managers reported are members of the Joint CHCP Management team.

CII-1: I think that Case C is in a slightly different place than other CHP's in the integration journey. We have got almost a track record of already part of a journey that has been taken, although it has not been done by legislation but we have done it by choice and some ways you're going to take forward (R14, Head of Health Service)

CII-2: You need to have a shared understanding of where you have come from before you can have a shared understanding of where you are going to go to..... That takes time and commitment (R11, Social Care Services Manager)

CII-3: I think that [integration] very much depends on the stage of maturity of the current partnership. So I think we have got much greater understanding of the separate histories of the two main agencies and perhaps many other areas and that allows us to think forward with a shared view of where we need to be going in the future. You need to invest in that (R11, Social Care Services Manager)

CII-4: I think that [innovation] does occur but I think what's particularly positive about Case C is that it occurs within an environment of shared strategic goal...for example re-shaping care for older people.... there was a contribution to a shared vision that was important (R11, Social Care Services Manager)

Managers' report pride and experience in engaging with integration at both the structural and service delivery levels. The future agenda for change related to integration and joint working is embraced positively including the challenges that come with it.

Theme 2: Managing With Complexity and Ambiguity

Case C has a formal partnership structure with agreed goals, HR policies, roles and relationships and is working towards a wholly integrated interdisciplinary management structure for all staff. The experience of attempting to integrate staff into a new structure as demanded in the future and its associated challenges such as the terms and conditions of staff are perceived positively

CII-5: We have already had an Accountable Officer from a governance perspective as a single point of contact with our joint director. We have already started the journey of looking at joint processes of performance and monitoring and how we can take things forward (R14, Head of Health Service)

CII-6: That very much depends on the stage of maturity of the current partnership. I mean we are talking about agencies that have very different aspirations, very different cultures, very different governance models and in many ways you need to understand the differences in those models. You need to have a shared understanding of where you have come from before you can have a shared understanding of where you are going to go to..... That takes time and commitment.... I think some of the things that have helped is relationships built up over time and relationships are a good way to start getting that shared understanding (R11, Social Care Services Manager)

CII-7: I think that the main challenge at all levels in the org moving forward to integration is around the culture and the experiences of people in the process....Certainly from our experience, I think we have matured over time and because we are co-located as a management team, our understanding of each other's business has improved vastly which helps us to see where we have similarities and differences.....So you're trying to make the best use of people's expertise and knowledge and resources as well (R12, Primary Care Manager)

CII-8: T&C's are quite separate....and we have made an active decision, for all the right reasons I'm sure, is that staff will not automatically unless they choose to do so transfer across to the other organisation in terms of terms and conditions of employment (R15, Head of Council Services)

A pro-active approach and advanced planning is visible across the existing partnership and the utilisation of prior experience is considered an enabler to manage change. Emphasis is placed upon developing shared understandings; practices and processes. Managers' report collective experiences and shared learning arising from past dealing of challenges together. Decision making towards the planning for upcoming legislative changes is evident and a corporate body model is envisioned.

Theme 3: Service Logic and Value Creation

Shared understanding and practise enables user-centred services. Understanding user needs becomes key in joint planning and integrated service delivery

CII-9: At the end of the day, what we are interested in is outcomes for our customers ..., our clients, our patients. If they get better service where in one visit they can get multiple services through one of these resources then that's key success really (R15, Head of Council Services)

CII-10: its not just about working in partnership with our immediate agencies but actually looking at the wider picture of things...(R12, Primary Care Manager)

Service value is derived from a shared understanding of what is important for users. Form following function is in practise.

Theme 4: The managerial remit: roles, responsibilities and relationships

Through experience of being in a CHCP arrangement overtime, managers' acknowledge that managing across organisational boundaries and service disciplines is of different nature than required in more vertically integrated or networked organisations.

CII-11: It's almost a certainty that the manager of a team will not have expertise in all of the disciplines, and indeed quite likely, not to have the greatest expertise in any single discipline. So there is that challenge of being able to manage such a team. And I think what will apply going forward in the integrated model is an extension of that.....as well as the challenge of professional grouping challenging you on your knowledge, allowing you to have authority and responsibility for an area of work, actually that extends them just beyond just the mere profession, it extends to an entire agency model (R11, Social Care Services Manager)

The challenges for the managerial remit are associated with knowledge; managing across agencies and dealing with multi-profession groups in integrated inter-agency teams: the managerial remit will need to extend beyond professional and agency confines towards a holistic service model.

Theme 5: The Learning, Training and Development Of Service Managers

Service managers in an integrated environment emphasize the need to learn to go beyond professional siloes and organisational boundaries to treat services holistically. They highlight that T&D efforts must improve their willingness and ability to go beyond their existing intra-agency set-up's and relationships and move to multi-agency service delivery and relationships.

CII-12: That would be particularly challenging because of the way our professional groups are educated and around their personal identity about what it is that they do as a profession... it gets reinforced by the professional bodies who are very protectionist (R11, Social Care Services Manager)

CII-13: I guess it's those siloes that are always going to be the issue and having a leader won't be in those siloes (R13, Business Manager)

CII-14: I think that a role like mine, it's important that you've grown up in the profession. People respond to style so my leadership style suits to get things done....I don't think necessarily you need formal qualifications to do this role but you need the opportunity to see the world in a different way (R16, Clinical Director)

The evidence suggests that managers must go beyond siloes and demonstrate leadership.

Service Managers who come from a clinical or professional health background identify a lack of support and opportunity for generic management and leadership training when entering into a managerial role.

CII-15: My view is that there has been very little shared T&D.....when I came into a management post, the lack of support from moving from a clinical role into a managerial role was woeful...When you move into a management role, there is no toolkit or expectation that you need to be trained to do the work. You have to self-initiate. And I feel very strongly about this because managers particularly are left floundered... (R12, Primary Care Manager)

More support in terms of training and development is called for to facilitate the transition of clinicians into managerial roles.

In terms of skills and behaviours for an integrated service context, managers do not identify or associate with any definitive or comprehensive set of skills or competences to operate in an integrated service system, but rather embrace ways of working that enable integrated service delivery.

CII-16: A whole raft of skills and competences there it's pretty difficult to say if there's any one set of thing.... I think there is a need to be fully aware that it is a continuous process. You don't suddenly have the skills. Its everyday about there are things that will challenge you to think differently or to manage differently so there is no one size fits all and one size doesn't fit every situation (R12, Primary Care Manager)

CII-17: I think it's very tempting to just come up with a glib that the management of change is the key competence. But actually if I was to think 'what is it that enables somebody to manage a change effectively, I think you need to have a whole range of competences. I don't think there is anything that you can just have the roll of that's a surge of management of change certificate, you can now manage change. To be able to do that requires a whole set of skills (R11, Social Care Services Manager)

CII-18: You're dealing with people, there is a need to continually to remind yourself that you're here to serve public and a population, because what we provide are services... If we lose the sight of what we are here to achieve by clouding that up with fancy terminology, that doesn't help you to develop competences that you need to deliver the outcomes that your there to deliver (R12, Primary Care Manager)

The findings highlight the ability to manage change continually and remain user-focused as being vital rather than thinking about generic competence types because managing will be context dependent.

In relation to MD, informal and non-generic forms learning and development are welcomed by service managers for a future integrated service environment

CII-19: So there will always be that need from an experiential element of it. And being able to share with other managers, getting advice, using support networks like mentoring or coaching can be invaluable but it has to be tailored to the individual's needs (R12, Primary Care Manager)

Learning through experience is valued.

CASE D

Theme 1: Perceptions of Change In Joint-Working And Integration

Collaborative and joint working is viewed to successfully exist in CASE D and the integration agenda is viewed largely as a matter of financial concern around which planning for integration is taking place between agencies..

DII-1: I know where we are at the moment looking to budgets and what's in and what's not. And I think the guidance would suggest that everything should be in one pot unless there is a really good reason for it not to be....So the politics of that is going to be really quite difficult and I suppose it's how we decide to work through our services and decide whether they are in or not (R22, Head of Planning and Performance)

DII-2: There is a definite try to push things on to try and address the structural issues and the systems issues....In terms of people doing the work, are actually a lot more focused on the history of the NHS board and the council working closely together. The point where everybody falls apart is money and budget. (R21, Joint Manager Learning Disability Services)

DII-3: The joint working bill should drive the absolute necessity to get on and do something about integration. It will be the driver to a pooled budget or a proper joint financial system.... we have developed joint reporting systems, joint performance systems, joint policies and guidelines around things. For us the matter is the financial system (R21, Joint Manager Learning Disability Services)

The findings reveal that particular aspects of the integration agenda are of concern: these being the budget and finance related matters and what services will comprise part of the future partnership working agenda.

Managers view service integration to be occurring as an incremental process over time that needs effort at the senior executive level if it is to succeed.

DII-4: From a managerial perspective, it's a evolving picture at the moment as we are just starting out on that journey in CASE D (R20, Head of Children's Services)

DII-5: I think it's at the senior level, the CHCP level is where there's a huge amount of work that needs to be done in relation to two organisations coming together. (R21, Joint Manager Learning Disability Services)

DII-6: I think there is still going to be a degree of variation but I think the imperative to get on and do it.... you still have some leeway to make some local adaptations or cater for local peculiarities.... But the very least older adult services have to be properly integrated. And that has galvanised Chief Exec's into actually making sure that it's going to happen. I think before there just wasn't the incentive, the imperative, or indeed the trust there to begin that journey.... I think the money is going to remain an issue (R17, Associate Medical Services Director)

The findings suggest that integration is a sequential process that brings change incrementally and that the need to integrate at the top executive levels is important for integration success.

Managers predict a corporate body model for governing future integrated service models since terms and conditions for employment of staff across both agencies is seen as a troublesome issue to resolve.

DII-7: At the moment I think there's a pathfinder board that's being set up..... We are going for the corporate body model. Huge challenges around T&C's of staff with Health Board staff on national T&C's and Council staff on local T&C's. And the gulf is getting wider and that is bound to cause resentment as you have two members of staff delivering in very similar roles but actually paid very differently (R20, Head of Children's Services)

DII-8: I think it has been foreseen that that would present quite significant workforce difficulties before you go too far along that path....So in Case D the thinking is that we are going to go with a Body Corporate... And we have already started developing a shadow board alongside our existing CHCP to begin that work and process of starting to bring people together. (R17, Associate Medical Services Director)

DII-9: Politically we'll develop a body corporate, we will have a health and social care partnership.....we want to put everything in it from the health side, the council don't want all in.... One person's integration is another person's fragmentation (R19, Head of Service Improvement)

DII-10: The one thing that a lot of people are concerned about that they will still remain on one side of the area. The T&C's of employment... the whole thing about taking over...That's at every level from senior management down to the different grades of staff (R21, Joint Manager Learning Disability Services)

A large concern for the T&C's of employment for staff is shown by managers. Adopting a corporate body model is seen as a way forward without which separate agencies are seen as unable to develop a way forward.

Theme 2: Managing With Complexity and Ambiguity

Managers highlight that the nature of responsibility will change and become more multi-agency and that it becomes a challenge to do decision making when operating in integrated roles. Managers will need to understand cultural differences among agencies, understand how teams in other agencies operate and be willing to do things differently and take decisions in different environments. There is also the view that middle managers are going to be anxious given resource constraints and professional backgrounds.

DII-11: We work in multidisciplinary teams but there are definitely challenges. It's at that level of responsibility say when you were managing a social care element it would be quite difficult because it would almost feel like your responsibility and whether if you have the skills to manage the social care element of that patient. It that boundary crossing....I think from a management perspective that could get quite tricky (R22, NHS Head of Planning and Performance)

DII-12: ... folk are going to be much more anxious and protective of their own sort of set of resources...Its actually the middle cohort... particularly the middle managers that will be anxious for their jobs, they will be defensive of their budgets, they will perhaps wear their own professional backgrounds on their sleeves. That's where the tensions will arise and that's where the fallouts will arise (R17, Associate Medical Services Director)

DII-13: People become very protective at the beginning and holding onto what they know. ...There will be that difficulty around letting go and moving on and doing something in a different way (R21, Joint Manager Learning Disability Services)

DII-14: The landscape we are going to be working in our there is going to be quite different. There will be far more third sector agencies involved....I think we will have to understand difference in culture and at the moment there is a huge difference in NHS and Council (R20, Head of Children's Services)

DII-15: The big issue is that where even senior managers, where they will happily make a decision in their own environment, they won't in an integrated environment (R19, Head of Service Improvement)

Managers' report anxiety and consciousness in moving towards an integrated environment. They perceive challenges such as decision making in a multi-agency environment and professional grouping to cause defensiveness and tension.

Theme 3: Service Logic and Value Creation

Joint service delivery at the locality level is considered to be healthy despite a squeeze in resources while exclusive co-terminosity of the Heath Board with the Council is considered an advantage in terms of planning future integration and designing service delivery.

DII-16: I suppose integration at the small scale, joint bits of working and making closer links, trusting each other and chairing agenda's at the local level..... We are lucky in xxxx that we are co terminus because that has helped. (R18, ADP Manager)

DII-17: I suppose we are quite fortunate to be small enough to make things happen quite quickly but we are big enough to make an impact..... Having one local authority with one relatively small health board lets us implement things quicker, it should in theory (R22, NHS Head of Planning and Performance)

DII-18: Yes, single Council, single Health Board... so it should be relatively simple in that respect, atleast we don't have to span boundaries, and we can begin to look at how we match our localities (R17, Associate Medical Services Director)

DII-19: There's a lot of good work going on locally, but the goal posts are changing in terms of the financial requirements and the resources we have got to address service are getting less....Now its about saying, how can we be smart, we are far more outcome focused and outcome driven now (R20, Head of Children's Services)

Support for local driven services is visible. However, a strong orientation and concern towards resources is evident among managers as they plan for a future integrated service.

The case for planning and delivering services locally is strongly supported while the local context is given importance over national agenda's. The local set-up is seen to be important in determining shared outcomes and joint service delivery while looking beyond periodic management trends and focusing on effective services is reported.

DII-20: I think it's very difficult. You can't have something that is the same in every area. It's interesting when I started this work I thought I'll just phone other ADP's and see what they have done. And every single one is different. Some have no voluntary sector, one of them commissioned out the health service and in between there is a myriad of things....it would be impossible for the government to say you have to do things in a particular way (R18, ADP Manager)

DII-21: It's about on the ground working and everywhere it's different. So we are just looking at a new spinal AHP pathway, so there's one national kind of pathway and everyone is to implement it. That has seen quite a few issues because not every NHS Board can. So it depends on your population...We are not classed as remote or rural but some of our distances between our towns are quite a lot, so for us to adopt national, ...it might not fit exactly....Locality can absolutely not be ignored. (R22, NHS Head of Planning and Performance)

DII-22: I've been around long enough now to see the trends and models as they come and go. I was around when self-managed teams was the vogue, but never got off the ground. We have been through several years of lean methodology in Case D, we haven't given up on that yet I would have to say....but the big anxiety is that our leadership teams, the chief execs and the executive directors. When they change over the model changes with them. A few years ago lean was the way we do business in Case D. ...And we are very programme orientated at the minute with project implementation documents and diagrams and all that. I think there are plenty of ways of skinning a cat, the question is does it get things done (R17, Associate Medical Services Director)

The findings indicate both co-terminosity and the geographical setting to be important elements in determining shared outcomes and integrated service delivery. Seeing past holistic management models that are viewed as transient to focus on service effectiveness for the user is considered important.

Theme 4: The Managerial Remit: Roles, Responsibilities and Relationships

Managers' seem concerned about their future ability to deal with integration. They stress on the need to develop trust and credibility in their roles and relationships while understanding both organisations.

DII-23: I think it would feel quite a big of a challenge and a hot house when it happens....I think as a manger you need to be pretty clear where to go to find out what was where. I do expect both groups feel quite dislocated and there could be quite a lot of staff dissatisfaction (R18, ADP Manager)

DII-24: It takes a lot to understand the roles and remits of the wider integrated team.....it's about how we work in a way that can build up trust...I think there will be lots of work to be done in having credibility in a team. (R20, Head of Children's Services)

DII-25: The manager's role will change because the manager has to have that breadth of understanding of both organisations and being able to think behind both organisations (R21, Joint Manager Learning Disability Services)

DII-26: ... my worry is that people will resort to authoritarianism in their managerial styles when in fact this is the very time you need engaging (R17, Associate Medical Services Director)

The potentially new multi-agency and multi-profession working environment is seen as causing difficulties to managers in their work.

Theme 5: The Learning, Training and Development Of Service Managers

Managers place a great deal of focus on leadership T&D and distinguish this from management T&D

DII-27: I think the actual training investment is in supporting leadership....It takes a lot of energy to make progress in all of this. And I think what we have got here is the beginnings of a management structure that have both organisation opening up to allowing other managers in. (R21, Joint Manager, Learning Disability Services)

DII-28: I spent a year doing the 'managing the future' course. And it was about not management it was about leadership....so I think the focus is on leadership rather than management (R20, Head of Children's Services)

DII-29: I've certainly appointed people with all the right competences who were all appalling people to work with. So you can have all the competences that you like, but the proof of the pudding is in the eating. (R17, Associate Medical Services Director)

Managers report extensive attention to leadership development and while skills such as adapting and mediating are reported, competence based management development is not adhered to.

A lack of management training is identified. Managers are also presently deemed to be unequipped to manage in an inter-agency environment and need to be trained specifically for it

DII-30: I don't think our managers have the necessary tools, training, background and managerial education that they need to do their jobs..... NHS managers coming from a clinical background need to take much more seriously their support and training, skill set needs rather than letting them flounder and learn by mistake. The NHS has a habit of promoting people into managerial positions to the level at which they just fail....I think much more though needs to be given how you support people in doing (R17, Associate Medical Services Director)

DII-31: If you are going to train people explicitly at being integrated managers, I think there's obviously the bit that just understanding how the different systems work. And we don't train them....(R19, Head of Service Improvement)

The findings reveal that management in CASE D deem managers to be unprepared for the integrated multi agency and multi profession context and that explicit training to deal with this need must come about. No existing OD function or department is reported in CHP-D.

Managers highlight the need to create the capacity to learn

DII-32: People do work in siloes managing one service and you've never had to interact with another agency that could be worlds apart. So it's getting an understanding and giving people the support to allow people to learn...So it's about how do we create capacity to learn and develop (R22, NHS Head of Planning and Performance)

DII-33: I do think one of the most valuable bits of training as a manager is coaching because it allows you to remember that you don't need to know everything.... I think the experience of being coached and then training to do coaching when you become a manager (R18, ADP Manager)

The findings reveal strong opinion regarding the nature of managerial learning and the purpose it must serve: that it be supported and gained through mistakes. Coaching is explicitly identified as an intervention for doing this.

Phase 3: THE FOCUS GROUPS

CASE A

Theme 1: Perceptions of Collaborative Working, Integration And Change

Managers report confidence about joint working and a positive outlook on future integration. The emphasis is placed on driving change bottom-up and importance is given to co-terminosity while financial governance is seen as a major driver. Planning towards an integrated shadow board for the health and social care partnership is active while financial governance is seen to be a major driver.

All-1: We have been quite good at that. It's about form follows function. Because we have dealt with a lot of working services in CASE A, we need to make sure that is factored into the learning as we build a H&SC partnership. So I think managers at the ground level feel more empowered that they are building some of that structures at the ground level and there is evidence there of a bottom to up approach. (R37, Head of Health Improvement)

All-2: So far the discussions have been based around the financial governance. (R38, Associate Nurse Director)

All-3: It is [finance] the driver at the end of the day because that's the one that gets in the way. (R36, CHP Localities Manager)

All-4: The co-terminosity is always seen as a positive because we only have one council. When you're in an area with 3 or more councils then it's seen to be more difficult. (R37, Head of Health Improvement)

All-5: Well yes from the Shadow Board point of view we had 8 members from the council and 8 from the NHS.... But there are discussion on how to have a more appropriate mix of senior managers in the overall project management rather than one person being at the centre at the moment who is just trying to sort out agendas for the shadow board. (R41, General Manager)

The findings suggest joint working at the local level to be given importance in the integration of services while the planning towards an integrated H&SC partnership board is active at both the strategic and operational levels. Support for change is provided

Theme 2: Managing With Complexity and Ambiguity

In the process of change, service delivery is reported to be affected. There is also concern of how the integration agenda at the national level as legislated is translated and managed down to the locality level. Another major complexity managers' report is how existing posts within the NHS board will become affected once health and social care integrate into a structural formation.

All-6: ...as time goes on there is going to be more posts either not replaced or replaced on an active basis, which could if we are not careful could give us an issue of capacity and capability as we move forward. And there was bit of that when we went from LHCC's to

CHP's and I'm just conscious that the length of time it took us to get back upto speed...there's the danger that the service slows down or that as we actually create the new CHCP that we from the NHS point of view may be seen to actually lack capacity and capability because it that's not coordinated...If we have this huge beast then how is it managed at the local level? (R38, Associate Nurse Director)

All-7: A lot depend on power dynamics and it comes back to the idea that if we are losing potentially strong experienced leaders at the more strategic level. Staff at the ground level can be potentially naïve and before they know there's a new process in place and agreed to and it's maybe not what it could have been. I think that's a real issue at the moment. (R37, Head of Health Improvement)

The finding suggests that as positions get replaced and experienced managers retire over time, a lack of leadership and capacity is envisioned for the future.

As changes come about, the complexity of politics and hierarchy in councils is highlighted which the NHS is not acquainted to

All-8: What we are not use to is the politicians. In the councils being accountable to elected members can be quite frightening at times. How agendas can change and decisions can be made because of the political dimensions, which is something we don't necessarily have in the NHS. (R36, CHP Localities Manager)

All-9: Again the council work in a very hierarchical way...So as a NHS staff, you might feel beaten down that decisions are already made through authority at higher level form the council. (R37, Head of Health Improvement)

All-10: I think we have to bite the bullet...we want to start having those conversations of how we are actually going to work together in the new world. And we haven't done that. We are still kind of on those different railway tracks (R41, General Manager)

This evidence suggest that adjusting to the political nature of change in councils; their different agenda and approach to working are reported as a complexity by managers and the council is seen as more hierarchical and bureaucratic. All such complexities are viewed as making joint working a challenge.

Managers at the same time report a sense of what needs to be done to address such complexities and ambiguities.

All-11: Maybe one of the things we need to do is to manage expectations of those above us....we have got to set up a management arrangement in such a way that is supporting... but let's not expect too much. (R41, General Manager)

All-12: So we will have to do is look at the gaps and overlaps and look to review them to make them meaningful to both sets of staff....Then there will be service guidelines that will be ones that we will need to bring together. So we are going to have quite a complex set of arrangements. (R36, CHP Localities Manager)

Managers show a sense of what needs to be done and seem to take the lead in making sense of the complexities and ambiguities related to change at a local level. Over expectations of fast change is cautioned against.

Theme 3: Service Logic and Value Creation

A strong sense of joint working at the local level is reported. Managers' derive value from user-focused service design and delivery. Opportunity to innovate services for users locally is seen as arising out of the national integration agenda and there is recognition of the need to create something new from existing agency systems.

All-13: In the journey on integration, I would agree that our product is the patient and I like to think that we are focused on that all the time. (R37, Head of Health Improvement)

All-14: Because its people, the closer you move to locality the more likely people are to work together and try and make things happen because they are focused on the patient or the service user. The further away you get from that, the more likely you're to be focusing on structure and budgets. (R36, CHP Localities Manager)

All-15: Putting patients at the centre in everything that we are doing. Any changes in pathways should be of benefit to patients...If you are going to have integration at that local level there is the chance here to really use it as a real opportunity. (R38, Associate Nurse Director)

All-16: It's going to be about how we create something new out of a few existing systems. (R41, General Manager)

All-17: I suppose there's something about H&SC integration, about a good revolution starting from the bottom up. (R39, Director of OD)

The evidence indicated driving the larger service integration agenda through collaboration and joint working at the ground level and bottom-up. Furthermore, managers perceive integration as a juncture through which to innovate services locally and move further beyond multi-professional working to multi-agency working and creating something new.

Theme 4: The Managerial Remit: Roles, Responsibilities and Relationships

There is recognition of the transition of the managerial role, responsibilities and relationships towards new service models. Managers' report eagerness and a sense of understanding in doing things in new ways and in their decision of how to go about it. They demonstrate a strong sense and confidence about what services can fall under the scope of integration and express desire to gain parameters and boundaries of their remit in order to perform well.

All-18: Coming from uni-profession to multi-disciplinary, now we are going to be multi-agency. And for those on the ground its understanding the processes of the people who we are working with, their roles and their remits and moving into that new sphere. ...Change for my staff group is about learning the new processes of the people that we work with. (R35, Deputy General Manager)

All-19: In the council it's done that way and in the NHS it's done this way, and which one is going to win. It's actually going to be about how we create a new way. (R41, General Manager)

All-20: Taking the best from both...Start with the ones easier for the organisation to start with services that are easier to approach, and learn from it and the process. (R38, Associate Nurse Director)

All-21: ...perhaps deciding what parts of the service that could be quick with that, which can naturally come together and could be developed, rather than saying everything has to change. So just focusing on the bits where we actually can make a difference and building on the strengths. (R37, Head of Health Improvement)

The findings are indicative that the managerial remit is perceived as changing and managers demonstrate a positivity about achieving change and innovation through what they will do and how. There is pro-activeness for working in new ways and in thinking about service design

Managers' report that operating in integration posts and integrated teams will require them to work with two separate sets of policies and separate performance management systems since staff will retain their existing T&C's of employment.

All-22: But if we start from the premise that peoples T&C's will remain the same, then the KSF is an integral part of the Agenda for Change Pay Modernisation Agreement. And therefore NHS staff will remain committed to ensuring staff have a PDP under the KSF arrangements. And the council have their performance management arrangements and it was called Contribution Management Scheme. A KPI scheme essentially. (R39, Director of OD)

All-23: Applying two sets of rules in terms of conditions and policies because if you accept the premise as currently understood...that staff will retain their employment positions, it could envisage quite easily as appointment of a manager whose managing an integrated team where staff are under two T&C's.... Which I don't think we are yet in a position to answer. (R40, Head of L&D)

This suggests that the implications of working with two different sets of processes, performance management systems and different T&C of staff for are unsolvable complications and limitations of integration that will continue to be a challenge for management.

Theme 5: The Learning, Training and Development Of Service Managers

Managers demonstrate the desire for shared learning across agencies while showing the willingness to engage. They highlight the need for top executive levels of both organisations to initiate and support joint T&D and learning. Managers also highlight the need to acquire knowledge about the difference in cultures and contexts between agencies.

All-24: I think its important for our staff to ask to go attend these meetings. So that as things develop they fully understand the context and the culture because we are struggling with it even at this level so for staff that are more junior going out to meetings it's even more difficult for them to have that knowledge. Even though devolved to the local level it is still bureaucratic as there's 1 or 2 people up there. (R35, Deputy General Manager)

All-25: No, I think it needs to be initiated through the senior management of both organisations. That hasn't happened yet and that needs to happen. And I find those of us

that have any kind of voice at all need to push on that one. Some of it is trying to link up across CASE A at the moment as well. (R41, General Manager)

AIII-26: Having conversations at the very senior level is important thing to do given the differences.... I think that bit at the top needs to address such things fairly quickly. (R34, Head of Physio Services)

The desire to engage with inter-agency learning and development is evident but support from the executive levels of both organisations is deemed necessary for this to be put into practise.

With reference to informal learning, action learning sets in principal are identified as a beneficial MD intervention but unsuccessful for the current drive of H&SC integration. The use of coaching is also identified as an intervention.

AIII-27: There's also an Action learning Set funded thru the JIT for the senior managers but I have to say that become a tick box....Because we didn't decide we needed it collectively and shape it, then we've not used it to its full advantage. ... There's been a number of sessions. Has been helpful to work out some of the stuff that others did, but other than that it's not been a success. (R41, General Manager)

AIII-28: What came out of that we weren't too clear about. (R38, Associate Nurse Director)

AIII-29: That's where if the action learning sets if they had been set up in a different way would have been really helpful (R34, Head of Physio Services)

AIII-30: The two areas that have been the most robust in outcomes and longevity would be the coaching sessions....One to one period of coaching for managers involved in change...The second one would probably be the action learning sets that have grown out of what was part and parcel of our formal Management Development programs. (R40, Head of L&D)

The finding suggests that action learning sets as a MD intervention are supported, but their application for the existing H&SC integration context have been under planned, underutilised, and therefore unsuccessful.

Managers take ownership for both organisational and management development at the local level and see the OD function to do the same but at a wider level across CASE A. The need to transfer inter-agency learning from the local level to levels above where planning is done is highlighted.

AIII-31: Even in the NHS, OD as a department only does a lot of what we do but at the wider L&D. (R38, Associate Nurse Director)

AIII-32: There's the thing about it being everyone's business. And the terms we have made around locality planning and local management groups have taken us so far in terms of service modelling stuff and that's how the OD work is done now as we learn how to put a service together but in terms of growing leadership there's a bit of a gap. (R35, Deputy General Manager)

AIII-33: But really for me it's about transferring what these folks are learning at the local level into our learning as well as we move forward. (R37, Head of Health Improvement)

The finding indicates a sense of ownership and responsibility of MD is evident among middle and senior managers.

Managers place the emphasis on rethinking leadership for the integrated service context and developing leadership capability among managers to lead in localities. Leadership development based on context and through action learning is advocated

All-34: Even if not in its formal sense, there's something about the collaborative leadership program that we ought to be learning from. (R41, General Manager)

All-35: I see it as an important leadership role and I am quite excited by it. I see it as an opportunity to break the mould of the past and the inherent limitations of our rational managerialist practices....I think of the need for leaders to transcend that narrow view of the manager to develop, as the word is, 'collaborative' management approaches that require the person to work effectively across traditional, professional and organisational boundaries, and to work with and through people and to achieve results through people. That required us to shift the paradigm away from the kind of centralised command control models of management to a more supporting and enabling style. (R39, Director of OD)

All-36: The SSSC have just introduced their leadership framework. And all these Leadership competency frameworks show a remarkable similarity. They say all the right words but my sense of it is that the leadership develop we need to do is context dependent and therefore needs to be rooted in the real lived experience of leaders working together in the field. And I'm thinking that this why locality leadership development is so important. (R40, Head of L&D)

All-37: The NHS default position of command and control is not going, and there is a general recognition, that it's not going to get us to where we need to be in terms of integration. And therefore the leadership task is more around creating a supportive and enabling environment. SO that people can make sense of integration within their localities.... So we are looking to the theory of transformational leadership and adaptive leadership...that will support and enable effective integration at a locality level....lets focus on localities which is where front line staff make a difference and providing services to those we serve. (R39, Director of OD)

The finding suggests a pivotal focus on leadership among managers in order to deliver inter-agency services and a shift away from traditional leadership models to context based adaptive leadership models is identified.

Managers identify help from national T&D providers to support MD interventions for health and social care integration. They identify making use of designated change managers who can facilitate service managers through the change process.

All-38: So we have been using JIT around those kind of things: developing the board and creating an action learning set for senior managers. (R39, Director of OD)

All-39: JIT has been all over the development agenda of setting up the transition teams and shadow board. In xxxx anyway, can't speak for anywhere else. (R40, Head of L&D)

AIII-40: I think the IHM have picked up on that and the majority of things they tend to be offering is about the skillsets of a leader or manager in a complex adaptive world where integration is. (R40, Head of L&D)

AIII-41: The two people helping to oil the wheels of the machinery are called Change Managers, that's their designation but they tend to be very much in the mould of a project manager rather than an OD practitioner supporting the people and cultural shifts. (R39, Director of OD)

The OD function's effort to provide support for MD and their coordination with national T&D providers to facilitate managers in making a transition towards integrated service delivery is identifiable.

An organic, non-programmed and non-generic approach to MD that is different from past practices and mind-sets is being encouraged.

AIII-42: In 2 or 3 months we could easily knock up an integrated MD programme....However we have discussed that over a number of years but fell foul of the fact there that we are creating an approach that tries to address needs that are really individual. At the time we looked at it because we were under pressure by particular rationalist structural leaders as it were. That's what they wanted to see because that fitted their mind-set. (R40, Head of L&D)

The finding suggests a shift in both thinking and practise from generic MD approaches to more context based and tailored MD approaches for managers.

To conclude, these findings from Case A are analysed and discussed in Chapter 6 of the thesis

CASE B

Theme 1: Perceptions of Collaborative Working, Integration And Change

Emphasis is placed on pre-existing joint working and the lessons learnt from past integration experience in the build up towards future health and social care integration that will be legislated under the Public Bodies Joint Working Bill. Case B is at an initial stage of planning for the change and managers' report no information or opinion with reference to the kind of partnership working model that may be adopted.

Bill-1: Actually a lot of the work that was going on at the time has still continued in terms of the way in which services are delivered... health as social care integration is not new. (R27, HR Director)

Bill-2: Most of our work is currently joint working. We are not working in an integrated culture but 80% of my work that I deliver is in partnership with acute, LA and education and SW colleagues.... I think this time going into integration from by NHS perspective that we are in a better place because the last time it felt a bit rushed and even not thought through as well.... I think now we are in a better place and staff are much clearer about what is the unique bit that they bring (R26, Head of Primary Care and Community Services)

Bill-3: The advert for the joint officer's post is out this month.... The discussions with the council are not complete in terms of services to be included and the structure. But there is a project group set up to look at some of the key aspects of it all and therefore start to do thinking around things like what does a locality look like, what are the governance issues etc... there's more thought being given to the run up..... (R28, Head of OD)

Terms and Conditions for employment of staff and budgetary issues are cited as challenges with upcoming change and structural integration efforts.

Bill-4: That's got to be the next step, and that will take a long time to get thru. That's gonna take somebody to say that actually services are going to be provided by A and then you need to move towards that, because T&C are completely different in terms of the way in what's there (R27, HR Director)

Bill-5: Well it will enforce it. Your basic structures will need to be integrated then.....so you've got the challenge of where the money is going to sit and how it's going to be managed which was at the heart of some of the questions that were asked before. (R28, Head of OD)

The findings reveal that the past experiences of integration and learning from it largely influences how managers envision future change. The planning and preparedness for future integration is minimal and which is seen as structurally enforced. A tradition of already existing joint services locally sets a pretext for engaging with future changes that is to be legislated.

Theme 2: Managing With Complexity and Ambiguity

Delivering services under uncertainty is seen to cause ambiguity and not the managing of change itself. Emphasis is placed on defining the parameters in which management of change is done.

BIII-6: I think the challenge is how do you that in all this ambiguity. So I mean, managing change is managing change is managing change so if people are experienced and able to do it they will carry on doing it whatever the circumstances, but if they are looking at uncertainty for what is happening to their manager and therefore that bigger picture becomes very unclear... (R28, Head of OD)

BIII-7: ...its about how well you can define because if you can define it well then you can do all the stuff you need to do. Health and social care became great cake makers for a period of time although we never actually made the cake, we just had the ingredients for it. And you could decide what you could do with them while as far as you came you came out with something that you could eat. (R27, HR Director)

Managers see change management to be a part of the process but are negative about it when there is ambiguity and uncertainty surrounding structural changes that are forthcoming.

Differences in policies, procedures, pooled resource allocation and power between agencies are seen not only as a complexity but also a limitations of joint working in an integrated set-up.

BIII-8: I think that's the nature of joint working that you work with two sets of policies. Its more about the concern that your working with 2 sets of disciplinary processes or policies, absence management policies, all these things... I was completely disempowered to do anything about any issues around governance, disciplinary absence, so that's actually difficult, but that's just the way it goes with integration (R26, Head of Primary Care and Community Services)

BIII-9: It was also a matter of different policy and devolved authority. In the NHS you have quite a high level of devolved authority at senior management level whereas in social care it's not the same level of authority. They make decisions based on individuals and its very much rigid. ((R26, Head of Primary Care and Community Services)

BIII-10: You need to remember that the council have one set of policy and procedures for the whole council while health have a considerable amount of services (R27, HR Director)

BIII-11: That's one of the biggest challenges for CASE B as a board is because if you give everyone the same you increase in inequalities in health. So if you want to target inequalities, then you can't give everyone the same...Such tensions will come to the fore and will be difficult (R26, Head of Primary Care and Community Services)

The findings reveal that such complexities and challenges reported by managers are seen as limitations and are treated as problematic. The findings suggest no planning or strategy among service managers as to how these agency differences will be resolved going into the future.

Theme 3: Service Logic and Value Creation

A clear sense of purpose and value is reported by managers as being user driven rather than by policy or structures.

BIII-12: Before we integrated we still co-worked in care plans and joint working for different client groups....If you look at it in terms of a performance, we have been doing better and

progressing more since we divorced. When we were a CHCP, there seem to be almost an inertia to make decisions. (R26, Head of Primary Care and Community Services)

BIII-13: The challenge in integration is to keep the best interest of the patients or clients and still be critical friends. Managing joint teams needs strong skill sets and it's very important to get out of teams what is best for patients and clients... (R26, Head of Primary Care and Community Services)

BIII-14: If people think doing services differently will make sense and have better outcome then people will work to make that happen, and will just ignore some of the structures. So going along the path that makes more sense rather than the footpath that's been laid out (R28, Head of OD)

The findings suggest that service purpose and value are driven through coordinated and networked designed and delivered service pathways focused on the users. Integrated structures are not supported as the driver of change but rather the interests of service users are.

Theme 4: The Managerial Remit: Roles, Responsibilities and Relationships

Demonstrating new values that evolve will be required of managers. The range of stakeholders managers work with will widen and will vary between sectors. What managers do and how they do it in joint posts will depend on what structures come into place and nothing further can be envisioned at present. More control will be exercised by managers as budgets will be pooled and staff from other agencies can be influenced to work in different ways. Networked management will change as managers will become responsible for various processes and pieces of work while at the same time manage exclusive networks.

BIII-15: Relationships, relationships and relationships are what makes the difference. So how is it that you get to know each other and still do the job.... there will be a set of values that will evolve for the new organisation that you would expect people to be able to show (R28, Head of OD)

BIII-16: For service managers, particular health managers who've never worked in an integrated world before is to become aware of the political agenda and local government level politics and how that works. There is a whole learning culture around this.... I think we under estimate it and assume we know it (R26, Head of Primary Care and Community Services)

BIII-17: Anybody as a service manager in a joint role will be doing something different than they are today. We don't know what structure will be....you have to engage with a wider range of stakeholders probably and depending on what work your involved in it will be different from sector to sector. But it's difficult to make it more prescriptive than that (R26, Head of Primary Care and Community Services)

BIII-18: Because you'll have pooled budgets you will have staff who work directly but previously you were trying to influence them to work in a different way.... It's how you manage that control will be difficult for people (R27, HR Director)

BIII-19: I don't think it will always be networks because there will be certain bits that you will be directly managing with processes you will be responsible for. So I think it will be a combination where there are processes you are responsible for but alongside that you

have some networks that are exclusive. (R26, Head of Primary Care and Community Services)

The findings suggest an emphasis on relationships and developing political acumen. Managers' report that no prescriptions are available but that they will have to engage in various and dispersed ways with a wider set of stakeholders. The remit of the manager is extensively seen to be influenced by structural changes.

Theme 5: The Learning, Training and Development Of Service Managers

Managers' report that existing T&D does not cater to the integration agenda because it does not deal with the issues and challenges associated with it. Also there is acknowledgement that training is provided repeatedly to only the one level of management when it is at the levels lower that require it. From experiences of H&SC integration in the past, being able to engage in T&D is deemed difficult. The OD function recognises the need to develop different values and behaviours that are useful for integrated service delivery but refrains from any planning and activity due to uncertainty about what integration structure will prevail.

BIII-20: ...where we get tied up in some of the learning and development because we start giving folk broadly the same stuff that we have been given them for years on how you manage services. What we don't do is deal with the cultural issues which are in there...we tend to provide all of that training to the same level of managers which are very senior. And it's further down the tree that the issues generate (R28, Head of OD)

BIII-21: I think that's where a lot of this stuff we provide for folks falls down because we don't actually get into this nitty gritty bits (R27, HR Director)

BIII-22: ...as a manager and managing integration, it was absolutely frantic most of the time...It was different in both organisations, your managing staff across, it was really difficult to find the time to do it.... (R26, Head of Primary Care and Community Services)

BIII-23: So taking an OD approach and developing the values and behaviours that people recognise as useful....And that's all part of the uncertainty at the moment because we don't know what that management team will look like (R28, Head of OD)

Even though there is recognition that T&D needs to serve a different agenda and through different means, caution is adapted given the uncertainty about how integration will affect the structure of the organisation.

In thinking about supporting L&D interventions, a range of initiatives at the local level are identified and supported by managers that are operational. These include flexible leadership groups in favour against formal programs; action learning sets for individual managers that address change for integration and include shadowing, mentoring and coaching as initiatives; along with a range of inter-agency joint leadership initiatives

BIII-24: So we would look at what we needed to do around leadership for integration and we have started with the leadership group and how they would do it. SO internally we

would do stuff but we would not necessarily do a program. A program would suggest that you put the meat in at the one end and the sausage out of the other end, and actually we need something a bit more dynamic (R28, Head of OD)

BIII-25: Something and bit more flexible and something intuitive....You'd be much better off with a flexible approach where people would pick the bits that would help develop their skills and leadership and management (R26, Head of Primary Care and Community Services)

BIII-26: We have already started the action learning set process for quite a big few pieces of change and really going into integration. So we do action learning, mentoring, we do shadowing and coaching, all these kinds of individual development opportunities So we have got an internal ready to lead initiative which is about preparing people to lead a piece of change for front line manager level (R28, Head of OD)

BIII-27: We also do 'common purpose', which is kind of a leadership program which has got council and the NHS and private sector companies involved with banks involved and business men and business leaders into the program as well. There's lots of choice for people there's lots in place (R27, HR Director)

The findings reveal that informal MD interventions are abundantly present in CASE B and are largely welcomed by managers to prepare for change. Informal and flexible interventions are favoured over formal and generic interventions.

CASE C

Theme 1: Perceptions Of Collaborative Working, Integration And Change

Management reports a great degree of preparedness for upcoming legislative changes and the future integration of H&SC. The integrating of strategy, processes and workforce planning between both agencies is already occurring. The future integration model to be adopted for CASE C is envisioned with confidence and considered to already exist as a set-up in the CHCP.

CIII-1: The CHCP in its current format pre legislation is pretty much the corporate body model. That is what we are operating in at the moment. But the difference will be around the finance arrangements and the IT which clearly the legislation goes a bit further on. But in effect we have been really working along that kind of model for the last 7 years (R23, Head of Council Services)

CIII-2: We have not even had a conversation around the lead agency model. All discussions have been based on the corporate body model because that's what we operate as near as at the moment. So to be honest we would never even have explored it (R23, Head of Council Services)

CIII-3: If there is successful establishment of a new corporate body model, a new H&SC body, then to my mind that does imply there will be change coming right across the board. (R25, Social Care Services Manager)

CIII-4: We have already started to integrate some of our processes. Fair degree of success in single assessments for client needs, we have integrated our performance management process in terms of strategic performance management, we are in the process of integrating our H&S processes, why would we not logically be taking that right through all aspects of processes (R25, Social Care Services Manager)

CIII-5: Yes, and I think the challenge is.... as we move more into all that there will be, because at the moment we have got aligned budgets. So with that comes the challenge of more integrated service provision, we have pockets of good practice in integration but it's not right across the piece (R24, Head of Health Services)

The findings suggest a clear preference and prediction for a corporate body model. Streamlining the existing H&SC partnership to meet future legislative changes is evident. Future legislation offers consistency to services and enables a step further in terms of financial governance.

Theme 2: Managing With Complexity and Ambiguity

The emphasis is placed upon the T&C's of staff being retained as they currently exist. The challenges of managing individuals in integrated inter-agency teams belonging to separate agency is seen to impact learning and how performance management is done.

CIII-6: I think what we are very clear about as officers, we still have to get political decisions around this but, is that T&C for staff will not change, we are not planning and

don't envisage going down the lead agency route where we would be transferring staff and T&C's. We will maintain current T&C's (R23, Head of Council Services)

CIII-7: I think its fair to say that the partnership has been called in terms of the Unions are very clear that they don't wish to see a change in T&C's of staff, so that in itself is something quite important (R24, Head of Health Services)

CIII-8: And that will also be a challenge for a service manager in a joint post because you will have, it's either a council service manager or a health service manager managing different staff with different T&C's, and clearly whatever side of the fence you are currently sitting on you bring more experience and more expertise in one area of work than the other, so there's a bit of a challenge in the learning there and how you do performance management (R23, Head of Council Services)

CIII-9: I totally agree .. in favour of having something that is consistent and applied in the same way, however in this point in time we have in NHS terms and conditions the eKSF and there are national government targets attached to that so we have a statutory duty to continue with them, and they would have to be revoked if we were going to do something else if we are to remain in the NHS...it's not a local system so therefore we cannot change that system locally... it's really difficult to put an integrated service together when you have two different pieces of work working differently (R24, Head of Health Services)

CIII-10: I suppose the other thing is that the council has been awarded the investors in people status, and the NHS are currently looking at that or that I suppose they are newer to that process, so I think that is possibly an avenue that would help us to join up although I hear what you are saying (R23, Head of Council Services)

Managers in the bid to address the complexity of T&C's for staff have ruled that the corporate body model enables them to resolve this matter. It remains a challenge however for managers in joint posts to manage the individual performance and appraisals of staff due to separate statutory national performance management frameworks.

Theme 3: Service Logic and Value Creation

Management report going beyond agency level purpose and planning if value is to be created. The associated challenges in achieving this are reported.

CIII-11: I think the Scottish government expects us to come out at integration. I think that we aspire to it, but yes we are a good way away from that being a consensus certainly amongst the major decision makers. And that vision is that people stop thinking in context of two separate agencies, so that people in the future will no longer distinguish between health and social care, they will be thinking single agency. And we will be organising ourselves single agency without necessarily having regard to "should that person be coming from social care side, from the healthcare side, should that service be solely staffed by people who came from the health side or the social care side. We don't in the future need to be necessarily need to be caught up with those kinds of divisions because they will become irrelevant in the future. That we will deploy people based on the most effective delivery we can have and that there's resources that will be available in a partnership as a whole. That will be some way off because that is a major cultural change as well as an organisational change, but I think that is a vision we aspire to because we see the benefits that will come from that.... I think if we are going to be successful in this integration journey you need to get away from thinking about "we are just a branch of" (R25, Social Care Services Manager)

Despite managers envisioning a holistic service system that goes beyond thinking at the agency level, there is recognition that successful integration this will require cultural and organisational change which remains a challenge because there is still divided thinking in terms of separate agencies.

Theme 4: The Managerial Remit: Roles, Responsibilities and Relationships

Managers' report the issue of T&C's of staff as influencing the roles, responsibilities and relationships of service managers. They emphasize that for the time being, managers will have to work with two separate performance and appraisal systems for staff in integrated teams but in the long run would aspire for single combined system between H&SC. A joint workforce plan is aspired and is reported to be at an initial discussion stage.

CIII-12: For the staff within it, they would still retain the T&C's for the current parent agencies. (R25, Social Care Services Manager)

CIII-13: I think we are a long way off that on an integrated basis at the moment..... At the moment we work separately, but as the HC managers says, we have an action plan around the development of a workforce plan and a workforce development plan. (R23, Head of Council Services)

CIII-14: My view is that there wouldn't be 2 separate appraisal systems or atleast we would aspire for that. Whether that happens from day one or whether it takes a few years to get there I'm not sure. It will depend on the willingness of the current parent agencies to agree to changes there. But for me logically if you we have a single agency then why would we want to have 2 separate systems in play and why we would want to have 2 sets of processes in play?..... We have agreed that we should have an integrated people plan, and workforce development plan, we are still using all these terms concurrently, but we have not really gone beyond that. But we aspire to have them. (R25, Social Care Services Manager)

The transition from two separate performance management systems towards a combined performance management system for an integrated H&SC service is reported as being dependent on the willingness of both agencies to agree to changes. Presently, no planning is evident for this and neither does any guideline from the joint CHCP Board exist, however it has been envisioned that a joint workforce plan will be developed but no timescale is applied to this.

Theme 5: The Learning, Training and Development Of Service Managers

Managers' report that existing T&D interventions are agency specific and focused around individual managers. There is no indication of joint T&D planning or practise for the integration agenda.

CIII-15: We have access to OD, because a lot of this is about transformational change. Its change management that we need the skills around. But we have sat to think about what that would look like and who would deliver it..... I would say it's been adhoc around individual managers that's about their personal development rather than the team development (R24, Head of Health Services)

CIII-16: Currently On the council side, we have our own L&D team who organise all the kind of all the mandatory training.... But we haven't gone beyond that to look at it on a joint basis.... Well I suppose until we don't actually know what the actual model will look like, it will be very difficult to progress further or plan appropriately. I kind of feel we are in a bit limbo just now because we know what we should be doing but we haven't quite got the go ahead to say 'on you go and do it this way' (R23, Head of Council Services)

CIII-17: We haven't really given any consideration to Management Development.... And as we work our way through the workforce development plan we probably start to identify some of that. Our understanding is that Scottish Government are about to be making available one or two resources for integration. So it might be that those resources could be used to buy in some appropriate MD. At the moment we haven't had any conversation on that at all (R25, Social Care Services Manager)

The findings suggest that no planning is in place for joint T&D interventions and that this is left as a matter for later depending on how the future H&SC partnership is shaped out. At present no consideration has been given to planning for joint MD interventions

Findings also reveal that the role of T&D providers to facilitate MD for managers' integrated services is not considered to be relevant by managers and in-house training is preferred.

CIII-18: Our utilisation of these T&D providers is mixed, because its very generic they do in some senses, so it doesn't necessary cater to Community Health Partnerships... (R24, Head of Health Services)

CIII-19: I went to a JIT event recently and it was a bit of dejavous, been here and had the same conversations.... It was all about integration. But not the service manager..... My view is that it is not that connected with what we are trying to do. It is all quite strategic. (R24, Head of Health Services)

T&D providers are considered not to offer anything related to the development of managers for the H&SC integration agenda. Rather, national T&D providers are deemed to offer T&D that is generic and associated with integration at a strategic level.

Related to MD, supporting the L&D of managers at present is done at separate agency levels and no joint processes are in place. Managers in new integrated teams will need to learn about technical aspects of managing and managing new types of teams in new environments. Shadowing and Coaching are encouraged as forms of action learning.

CIII-20: I think its fair to say that we do that individually at the moment, R23 will work with her Managers on a one to one basis as would I with my service managers on one to one basis and it cascades right down to the front line...But certainly we have not got a joined up process (R24, Head of Health Services)

CIII-21: ...there's two parts in that for me where im thinking of what we are doing in the future. One is the kind of technical side of that which gives people the actual knowledge

and skills around performing.... So if we are going to have mixed teams then they are going to have to understand the technical policy side of things and how they actually implement that and grievances and recruitment and all of these things...So I would call that the hard learning. Then there's also the stuff that sits behind that which is the softer stuff which is more about the inter-personal skills and how they actually take on teams. Because I think team building with a new set of infrastructure is going to be different and different challenges and I think that's quite important. So I would say these two things are important....There needs to be an element of shadowing as well. So that they can actually shadow people in other areas so they can actually learn by experience (R23, Head of Council Services)

It's about not telling but about coaching as well (R24, Head of Health Services)

Learning to manage change is considered important but no prescribed methods are deemed to enable this. Rather, learning through experience, action learning and small pieces of change are advocated.

CIII-22: For me the crucial competence will be the management of change. But I have always had difficulty translating that kind of competency into something that you can quantify it in an L&D capacity. So what might that look like that would be effective that would really make a difference to us.... I think it's fair to say that there is mixed experiences as to the success and value of these kind of interventions so I don't think there is a magic bullet here. I think we will be looking at a range of things (R25, Social Care Services Manager)

CIII-23: People actually learn by just trying small things of change and seeing how they work, learning from them and then moving them on. And I think it doesn't have to be a great heavy big leap type of training. So having an action learning set would be quite a useful thing to actually have (R24, Head of Health Services)

Here, the use of co-location is seen as a facilitator of the shift towards integrated service delivery since it enables exchanges of experience; allows learning to occur because it establishes relationships and trust; breaks down barriers and enables exchange of experiences and allows networking.

CIII-24: In here we have co-location and co-location helps to cement relationships..... I think we have matured over time and because we are co-located as a management team, our understanding of each other's business has improved vastly....I think you cannot underestimate how important co-location is, to actually have the chance to chat and talk. (R25, Social Care Services Manager)

In thinking about future MD interventions, managers highlight the need to try new and different approaches and improvise depending on the needs of multi-disciplinary teams and more importantly users in integrated services without being constrained by past MD approaches.

CIII-25: I think as we go onto this integration journey.... maybe that how we have structured ourselves historically isn't the way we want to be structuring ourselves in the future. So I don't know what that might look like, but it might for example look like multi-disciplinary teams that involve a range of professionals that are sitting in 2 separate agencies that you bring them together. Some multidisciplinary teams might be based on a geographical patch, might be based on a certain client group that our view is that we can address the needs of that client group better rather than having them organised on a

professional basis.... Those types of models will produce quite different demands in terms of how you would choose to develop that team of individuals...I think we have to just keep our mind on that, not necessarily constrain ourselves to more historical an approach (R25, *Social Care Services Manager*)

The findings reveal managers indicating no specific MD interventions but rather, recognising the importance of trying different ways and improvising approaches that can facilitate multi-disciplinary teams to deliver the best to users. Managers also acknowledge that managerial L&D needs to be facilitated in new and different ways to before since the nature of the services and the ways in which they are delivered has shifted.

CASE D

Theme 1: Perceptions Of Collaborative Working, Integration And Change

Managers perceive particular services being subjected to integration. Integrated services for the future are seen to be restricted by the existing managerial structure and the lack of planning and resolution between H&SC due to resource pressures.

DIII-1: I suppose for children services we are not in the integration plan so I suppose this will be for the adult health services colleague to respond to (R29, Head of Children's Services)

DIII-2: Our big challenge will be trying to deliver skills outside these walls. And at the moment we don't have that that managerial structure that would allow us to deliver services to patients in their own homes....All of our strategic thinking realises that will happen but until and unless the structure is in place we probably wouldn't be able to deliver an integrated services between secondary care and council services. (R32, Associate Medical Director)

DIII-3: ...folk have been working at the front line as best they can in an integrated way for years but the rubbing point comes usually when it requires commitment of resources beyond the individual staff..... discussions continue even this week. There is no clarity there is no agreement....Mental health and learning disability services are clearly in because we have been moving for 3 or 4 years towards more integrated services, but the rest is still dancing around each other (R33, Associate Medical Director)

DIII-4: This is really a quite difficult box at the moment. The easy box is public health, Drugs and Alcohol services are already commissioned. The really tough one is older adult services and that flow in and out of primary care and secondary care....And I think we are in danger of creating integrated things out there, but your still gona have that crucial fault line between out there and the acute unit. (R33, Associate Medical Director)

DIII-5: I think the rug was pulled from under that last Tuesday evening because the joint accountable officer which would have had financial accountability for all the money, that apparently has been removed doe to lobbying by xxxx. So if that's the case, the bollocks have just been cut off the whole thing. And if that's what they have done, the next 3 to 4 years we are wasting our time. (R33, Associate Medical Director)

DIII-6: The Euro is a great example of this isn't it. We are all gona work together and we are going to use one common currency but you can all do your own thing. That worked well. (R32, Associate Medical Director)

The findings suggest displeasure with the integration agenda and frustration over the inability to plan, address strategic issues and move forward.

Theme 2: Managing With Complexity and Ambiguity

A lack of trust and accountability is evident between health and social care agencies and managers. A need to clarify objectives and expectations between agencies is highlighted. Issues pertaining to budgets are seen as the main obstacle to integrated working between health and social care and resolution to budgetary issues is seen as a the only means of progressing

DIII-7: The fault line that lies just below the surface of both of these areas of endeavours as you would expect is money. You can commission integrated services as much as you like but where you commission it from half a dozen organisations that are fighting for survival and their share of the cake, your explicitly making it competitive. So commissioning equals competition in my head. (R33, Associate Medical Director)

DIII-8: It has been completely out of the picture until now yet which leaves us now with the exact budgetary problem that X leads to. Why can't we get the patients in? Because there's 30 odd patients in the hospital that should not be there. Can I get them out? NO. Why can't I get them out? Because I can't get them placed wherever they are meant to go. That's not my budget, that's somebody else's budget and they have a different priority..... That cries out for integration. But there is absolutely no move to integrate. ...As we sit here that is a huge problem with no sensible solution on the table or up for discussion... it all comes back to the money.... Reaching negotiation points is tricky. (R32, Associate Medical Director)

DIII-9: ...people don't understand the roles and responsibilities of specific agencies, so we have come together and are trying to deliver but actually we are duplicating and there are at time gaps that we are not aware of. So there is something very fundamental about almost going back to basics in terms of integrated working and to clarify what are the accountabilities and expectation as we work in a more integrated way (R29, Head of Children's Services)

The findings suggest financial governance and budgetary concerns to create a great deal of anxiety and pessimism among managers and seems to act as a hindrance in moving forward with planning for integration,

A solution to budget related complexities, resolution from executive levels of both agencies and the appointment of a joint officer are emphasized on by managers in order to progress with integration.

DIII-10: ...there is a process you need to go thru whereby you first of all align budgets build trust and then pool budgets. We are not even at the first step of any of that yet (R33, Associate Medical Director)

DIII-11: Even if you take my role, theoretically I am appointed into a joint post. It took one of the organisations a year to hand over the budgets for one element and the other organisation has still not done that and I am in a 2 year post. And what they are telling me is that they cannot give me operational responsibility for budgets within Social care and health, social work effectively, because they sit with service managers. (R31, Associate Director AHP's)

DIII-12: Our joint director of public health requested that ADP be accommodated in SBC building, and the chief executive of the council said actually that's a very good idea. ...we are not allowed to be a part of the telephone system that SBC Works through the computers. We are not SBC employees so we cant be part of that system. And even if we could be part of that system we then wouldn't be able to access our NHS intranet through that system because of the shifts in IT security. So what we have got is the 3 of us needing a desk with a dedicated telephone line and a hub for or computers in an area where all the other staff hot desk. And they them say "o here is NHS staff moving in and they want their own desks, getting their own desks". And that's the feeling. And that a very small thing but we don't know where we are going to be sitting in a few weeks' time. (R30,

ADP Strategic Coordinator)

DIII-13: And that confirms the perception of "them and us"They highlight just the difference, the whole mars and venus thing between health and social care and I think bridging that gap is an enormously difficult task (R33, Associate Medical Director)

DIII-14: You have to have the common accountable officer, common budget and that can drive the cultural change because the cultures are very different. You're getting people to volunteer to change their culture when they are trying to defend their budget and their professional positions. Unless there is somebody that has an overview of that, to me that integration is not going to happen.....And the only way that will work is if somebody with the chief operating officer or the chief executive role who is overall accountable for both of those budgets saying: by the way service managers, it's now different (R32, Associate Medical Director)

DIII-15: Both organisations are going to be scared of that post because that might commit resources in a way that they don't want to see implemented. When you think back behind the money, behind the money is power and control, ego and careers. The money is the proxy for that. I detect that at the moment people are not prepared to seed that sovereignty, that authority, that power, control and money to some other third person who might do things that they don't entirely feel comfortable with. (R33, Associate Medical Director)

The findings reveal that major difference of culture, ways of operating and budgetary concerns are evident in CASE D that create a large trust deficit between agencies and managers. The agenda for integration seems marred with these complexities that prevent managers from moving any further than existing joint working arrangements in their respective health services. Managers expect resolution from the executive level.

Theme 3: Service Logic and Value Creation

The findings suggest that agency differences, nature of public health service and the need to manage according to national frameworks all dictate service purpose.

DIII-16: I was managing B&Q and I had a set budget, and I simply say "Oh we don't make much out of screw drivers so we will stop selling screw drivers and we'll stop doing this and we will stop doing that and we can live within our budget and we will do the stuff that makes sense". But we cannot do that. So what we are told is "you must live within your budget, they must live within their budget, your gona have to arrange between yourselves to transfer some budget from them to you or you to them, due to the different stuff that you do, and by the way neither of you are allowed to stop doing the stuff that you do. You certainly can't stop doing what you already do. So that is the elephant in the managerial room because that's exactly what managers in the private sector would do. They would rationalise and they would trim. But we have been told as one of the givens is that you're not allowed to do that. You may become more efficient but you may not cut, and then you have to suss to somebody over there how you would do that and how you deliver these services for less than you have now without cutting anything and integrate without necessarily the budget to cover that. (R32, Associate Medical Director)

DIII-17: So where I try and get OT's to work differently with patients..."can't be done, we don't respond to anything in 24 hours and my service manager thinks I can't do it so I don't have to do it". As an associate director for older services and my counterpart in social care who was head of social care at that time, said yes we want to do it, make it

happen, it still didn't happen. Because the service managers said: "its my team, my budget, we can't respond in time, we are not going to come see this patient on the wards and get them home". (R31, Associate Director AHP's)

DIII-18: I think the partnership should be about finding a new way of doing things together rather than actually shoe horning one of the partners into the other partners processes. And I'm not sure that maturity of approach is actually there (R29, Head of Children's Services)

DIII-19: We need to create new staff, because the two old things are not fit for purpose. And you can't mash an orange and an apple together and create a new fruit. You actually need to create something different. But I don't know if that message is understood. (R33, Associate Medical Director)

The findings suggest that agency differences, nature of public health service, budgetary constraints and the need to manage according to national frameworks all dictate service purpose. Managers are keen for new ways of planning and delivering in order to create value but see a lack of maturity in doing so.

Theme 4: The Managerial Remit: Roles, Responsibilities and Relationships

Managers' report the need to articulate their contribution as roles and work boundaries become blurred. They identify the need to do sense making and highlight the need to deal with the complexities of other agencies.

DIII-20: As we work further, the boundaries become more blurred in terms of what we are delivering and what our roles are but that we must also be able to articulate what is the unique contribution that we bring as specialists to integration because that can get kind of lost in there (R29, Head of Children's Services)

DIII-21: The key thing for managers is how they handle that: being torn apart by policies and procedures, by funding, by budgetary and loyalties and by people above them whos loyalty might be to their own organisation rather than to the integrated working endeavour. (R33, Associate Medical Director)

The need to make sense during ambiguity and avoiding negativity in the face of integration challenges is reported.

The differences in T&C's of H&SC staff, having to work with two separate systems and the lack of trust bares a large impact on the remit of the manager going into joint working in an integrated environment

DIII-22: That's what's coming through strongly at the moment, is that there are issues around trust. A lot of people who work in the services want things to be fair and they want them to be just....That's the kind of key issue that comes through. Just even the hours that people work. We do have a common core staff group between AHP's between health and social work but they work different hours. (R31, Associate Director AHP's)

The evidence suggests a lack of trust and discomfort with dealing with separate employment T&C's of staff.

With reference to managing performance of individuals in joint posts and/or integrated teams, the need to comply with national frameworks is highlighted.

DIII-23: This cannot be done locally. We have to dance to the national drivers. Unless somebody high up who devised the e-KSF and KPI's get together and say "let's create an E-KSFKPI, or something like that. That's a job that needs to be done and then we can dance to that... it's taken few years to get e-ksf strutting along the run way, and to completely revamp it would take another 3 years anyway. (R33, Associate Medical Director)

DIII-24: We cannot not do E-KSF (R30, ADP Strategic Coordinator)

DIII-25: We have to do it (R32, Associate Medical Director)

DIII-26: And I can't see our LA colleagues "Ah alright we'll do e-ksf". I don't know what drivers they have and whether they are obliged to do their KPI's or not, but we certainly are obliged to do with e-KSF (R33, Associate Medical Director)

DIII-27: If you have a joint managers trying to double run two systems you're going to end up with managers who are going to be developing things and will just end up running two systems. (R31, Associate Director AHP's)

Having to meet national performance management requirements and dealing with two different systems while in a joint post are reported.

Theme 5: The Learning, Training and Development Of Service Managers

The case for MD is largely one where its lack is identified in the NHS while the same is perceived as being better in the Council. Nothing particular in the way of preparing managers for H&SC integration is identified.

DIII-28: Health is only just now grappling with the issue of management and leadership development. (R33, Associate Medical Director)

DIII-29: It is interesting how far ahead the LA is with developing their leadership and management throughout the professional posts right through to strategic. (R30, ADP Strategic Coordinator)

DIII-30: I certainly recognise the model where we have courses that do things like develop your leadership skills or try to make you into a future high level manager. But we absolutely don't have anything that says "by the way the nuts and bolts of doing the manager job are, your gona have to manage leaves, changes of jobs, sickness absence, disciplinary's... You don't get that. (R32, Associate Medical Director)

MD interventions at the local level are not identifiable. Manager's report attending national programs with no significant benefit reported. The findings suggest Case D NHS being behind their counterpart agency when it comes to the development of managers for the H&SC integration agenda.

The need to **train** managers to engage with basic management skills and performance management is identified. Managers are complacent of the lack of management T&D; the route to progression; a lack of respect for the manager.

DIII-31: So at CASE D NHS since 8 or 9 years, there has never been training on finance, training on recruitment, interview skills. So basic tasks you have to do and are responsible for and which terrify you when you're a new manager, never mind the leadership or developing others. (R30, ADP Strategic Coordinator)

DIII-32: Im coming from a clinical role into a manager role, it was a case of sink or swim about it...When you actually go into a different role you don't know what's not in your bag (R29, Head of Children's Services)

DIII-33: On the managerial side certainly in secondary care, what we do is put people into managerial posts and then we decide if we are going to train them to do that job, rather than doing it the other way around...What we do is promote them, and see if they are floating after 6 months and then we give them some training...In health you pick the ones you think that have got potential. If they fail you blame them rather than training them so that they can do the job. That might be different in the council, but that's what we do that's the culture in health... (R32, Associate Medical Director)

DIII-34: I think that there is very little respect for the management function, and there is a very discreet framework and that's very unfortunate because it is and you can tell the people who know what they are doing and can do it well. But we don't tend to value or support people to gain those skills in structured or unstructured ways. Often you are just put into the post with potential in inverted commas. (R31, Associate Director AHP's)

DIII-35: That's a bit harsh, but people try and do the best that they can, but I don't think so that they get the framework or the backing to develop. (R33, Associate Medical Director)

The findings suggest the learning, training and development of managers as being undervalued owed to the organisation and its history.

The lack of an OD function and Action Learning Sets as an MD initiative that could help reconcile agency differences and support MD are identified.

DIII-36: There isn't an OD function at NHS CASE D (R29, Head of Children's Services)

DIII-37: They had away with it... As a cost cutting exercise (R32, Associate Medical Director)

DIII-38: It disappeared (R33, Associate Medical Director)

DIII-39: It was a key factor and I think the counterpart within SBC is a T&D function, the same as it is here, but I'm not aware of there being an OD function. (R30, ADP Strategic Coordinator)

DIII-40: Our OD function I think is within our T&D function and the appropriate lead has got that within her limit but it's rather discreet. So it's not that we don't have it (R29, Head of Children's Services)

DIII-41: Yes it's just gone. (R33, Associate Medical Director)

DIII-42: I think another thing that isn't recognised is the role that OD has as a body of knowledge or science, or not, given the number of soft issues that are coming out around trust, communication, roles, responsibilities and joint learning. (R31, Associate Director AHP's)

DIII-43: There has been an action learning set being in place between H&SC that's been funded by JIT. I'm not sure how successful it has been in terms of the attendance....I think that is opportunistic because I don't think there is a planned programme for action learning around the integration agenda. (R31, Associate Director AHP's)

This evidence suggests planned MD interventions (i.e. Action Learning Sets) around the integration agenda and the absence of an OD function as being lost opportunities.

The role of national T&D providers is viewed as unrelated to the development of service managers and is instead focused on policy and clinical T&D.

DIII-44: It tends to be more professional or post grad medical education or specific special groups... And it's again about not having any role of the service manager because the service management is being the kind of the key factor that is going to deliver some of the integration. But it's concentrated around uni-professional groups. (R31, Associate Director AHP's)

DIII-45: I genuinely don't know if they have anything planned (R33, Associate Medical Director)

DIII-46: Majority of the stuff that comes out is attached to discreet policy areas (R29, Head of Children's Services)

The findings suggest no linkage and engagement at the management and organisational level with national T&D providers for the purpose of developing service managers for future H&SC integration.

Phase 4: OPEN-ENDED INTERVIEW WITH FIELD EXPERT

The outcomes from phase 4 emerged from the interview discussion held with a field expert using the same questions and topics are used in Phases 2 and 3. The findings incorporate the field expert's reflection of the outcomes from Phases 2 and 3. This section of the Annex is organised by Theme, illustrative of the process of distillation of the data and emergence of the analysis.

Theme 1: Perceptions of Collaborative Working, Integration and Change

Integration needing more and beyond encouragement

X1: ...if encourage is all its going to do, will have this same dialog in 10 years' time. There is nothing in the legislation that kind of says you must or you will or this is how it will be done... And it all becomes an aspiration and there is no real context of how that's going to be delivered.

Integration is complex and organisations are at too early a stage for integrating. There is a need to deal with the ground level operational issues and better partnership working before moving to integrated structural formations and what that means for managers

X2: I think it's doing that [refrain from the word integration] because it's too complex to start talking integration.

X3: We still come down to this bottom line that we are not dealing with those nitty gritty issues before you actually get to this kind of concept and it seems to me that we have got this brilliant idea of what the corporate body might be or what the lead agency might be but how that then functions or operates is always kind of pushed to one side.

These findings are analysed and discussed in Chapter 6

Theme 2: Managing With Complexity and Ambiguity

Addressing complexities and ambiguities even though they act as limitations, comes down to understanding context and addressing issues at that local level where services are planned and delivered (service design) even though complex. Good examples for joint working across agencies is evident but there lacks the learning from these examples and feeding back into the national models that are emergent.

X4: The reasons for me relate to the concern that T&C of employment for staff, the technical issues related to it are seen as a limitation. I would go stronger than that and say it's an absolute blockage because that concern is entrenched.

X5: I think we have seen some good examples... one of them was a CHCP in CASE C. And it was a good model, not without its tensions...but it seemed to have a finger on the pulse regarding some of the things we are discussing. But what I don't see is some of the learning. We talk about the learning organisations but I don't see how that is feeding

back into the models that are emerging now.... So I think we are going to see continuing tensions with no clear answers to lead agency or corporate body status at this time

X6: Because, management has to work with the context and it's the context that are changing whether that's political, whether that's cultural, whether that's operational. For me that context has to be realised and understood, and then management adapts to what it needs to do to deliver on that. I'm also not convinced at all that management when it comes to those issues has got a clear sense of where responsibilities lie and therefore where their authorities lie and ultimately where their accountability lies in that sense. And that is very complex.

These findings are analysed and discussed in chapter 6

Theme 3: Service Logic and Value Creation

Integrated services are about inter-agency and multi-organisational dependence. Increasingly, the purpose of services and their management becomes inter-connected (e.g. joint accountability) with multiple services finding common ground (shared purpose and value creation). Increasingly it is about management in context: reflecting upon and understanding multiple different contexts in order to be able manage within them (a system of inter-connected service contexts)

X7: It's about inter agency and about multi-organisational relativity. I remember when I started with management training you could draw these separate circles and coding all these different agencies and draw lines and say "this is all the relationships that the manager had", but today you would have to draw that and every one of those circles would have to be inter linked. They would have to be inter locked. Within each of those there is a common ground. Again it comes back to context. Managers need to manage and do what they do in the context in which they work.

Management increasingly is about looking beyond the immediate service function and organisational boundary and looking at the wider system in which services operate

X8: Systems within systems within systems....you can't change one part without impacting on the others.using an analogy, thinking of the adult manager...who has got there by going through larva stages and pupa stages. So reflective practitioners, becoming a manager of reflective practise and working within those contexts. I remember working in a hospital and the only thing I worked in was within my collection of wards that I was responsible for. And that was my focus. I never actually appreciated at the time that I worked within a unit, within a hospital, within a region, within a health service. I didn't see that. But now you see the bigger picture all the time, you see where those issues are....

Despite the desire for delivering user-focused services, there are issues of efficiency that remain.

X9: We argue that it's for the patient and it's the patient first, its about getting the best outcome for patients. But that's also said against the notion of cost effectiveness, value for money which we can break down into various dimensions

Service design needs to alter based on purpose and needs of the service and the demands upon it

X10: Until Saturday and Sunday in health and social care becomes like Monday and Tuesday, I just don't think we are going to get the kind of flow that the corporate bodies or the lead agencies are looking for.... It's that real sense that we have unsocial hours, we have shift work, yes care institutions have to be staffed 24 hours a day

Theme 4: The Managerial Remit: Roles, Responsibilities and Relationships

While acknowledging that such issues affect the managerial remit, the question remains as to what organisations and managers themselves are willing to do about it in their given context.

X11: If you want people to grow and develop and deliver this agenda, they you really do need to start prescribing for exactly what that role is. And you really do need to give people the space.... I think its actually about enabling managers to create their own space legitimately as part of their role....

X12: ...at what point does the bigger picture become appropriate for managers....YES, it is a political environment and managers need to understand that. I don't believe managers can afford to be apolitical. ...the question is asking how they are doing that. And I think it is either a conscious and active engagement or it is that sense of "not quite clear what is driving that but I'll go with the flow anyway". I know we can go back to all those models about unconscious competence and conscious competence and that kind of business but in the reality of it is that it's the context, its where that manager is and what it is they are actually doing.... It is about "this is it, and I'm a manager, put me in there because I know what those issues are" as opposed to "as opposed to "I'm just responsible for a group of people and a function and that's all I need to worry about and that's all I'll do"... I suppose that comes to the point of, do you actually want professional managers that are recognised as professional managers.

Taking on the task of addressing the issues at hand requires being professional and needs willingness. More importantly it requires the realisation and commitment to reflection as a task, activity and part of the managerial remit. Managers are more driven by performing and achieve targets as solution and less by reflecting and learning as solution.

X13: I agree that managers facing increasing admin....The other side of that coin for me is that managers don't value reflection because they are more driven by achieving targets than they are by actually taking space to reflect on what they are done. And so reflection becomes an 'add-on to' rather than an 'integrated part of' who they are and what they do.

The managerial role for integrated H&SC services cannot be prescribed since it is processes and people that managers deal with. As managing is of an unpredictable

nature, having boundaries becomes a barrier. Existing paradigm is to be role and task driven which limits scope and creates barriers. This dominates the remit of the manager creating boundaries until they learn to grow out of the scope of defined remits and shatter boundaries through experience.

X14: I don't think you can prescribe what it is that defines that management role.... because we are dealing with processes and people, then it is so unpredictable from that point of view that to have a boundary becomes almost a brick wall.

X15: ...there is such role preciousness and I'm wondering about the barriers that it creates...we are role and task driven, we have job descriptions, we are told what the limit of our job is. ...And when you start a new job the role is paramount, and there's just a little self down there. When you get to grips with that role, you start to bring other things into it about yourself, so the self begins to grow and the role begins to shrink, because at the point, the role begins to push outwards. And for me that is where the boundary shattering thing actually starts to happen.

Theme 5: The Learning, Training and Development Of Service Managers

Managers need to be supported in developing the right types of behaviours and attitude for an integrated service context which involve acting with resilience; courage; integrity; confidence; resoluteness and consistency. In developing and demonstrating such behaviours managers can be enabled to develop knowledge of the contexts they are dealing with and develop the resolve to address the challenges of integrated service delivery.

X16: Its about behaving accordingly...it is about not prescribing, its about ways of behaving within contexts. And that doesn't seem to set any boundaries.... Personal Resilience is the issue, day to day managers have pressure on them and its how you bounce back and its how you work with those issues. There's about courage and integrity – acting with courage and integrity....The other thing is about working with confidence...its about working with authenticity with other people and that's something I think middle managers struggle with....The other things are about resoluteness, about having problem solving, its about change management, and then its about consistency.

T&D in the NHS is highly fragmented and disparate while its focus is to enable people to do more with less. The focus needs to be on enabling managers to deal with transient contexts.

X17: I think the difficulty we have is that the NHS is pretty much chaotic...There is nothing tangible to plan for other than 'do the same for less'. It's all very fragmented. WE have workforce planners deciding how many staff we need without any reference to what sort of team it is that needs to be delivering... I think what you can only plan for is enabling managers to grow with the context to whatever it is changing to... to continually reflect how they are working with a changing context should be the plan... health service policy, frameworks, legislations are transient. The government is transient...So what is it that people need to sustain, to be resilient about, and fundamentally for me that is about behaviours.

The development of such necessary behaviours requires active engagement from managers and support from organisations. This requires organisations to treat managers' more than passive recipients of MD.

X18: ...there's all these different models for managing change, yes, learn about them by all means, but at the end of the day it's the way that you are behaving more than anything.... And it is for me fundamentally about knowledge of the contexts in which people are working

MD needs to be given importance and needs to move away from traditional programmic approach. Without being restricted to informal interventions, there is the requirement of facilitating and encouraging managers to be vocal about their L&D needs and catering to these by providing them with meaningful frameworks on individual basis. MD context takes precedence over MD form and content. MD needs to be context bound and deal with the actual pressures that managers have to address in order for learning to go beyond the organisation and become meaningful. Managers must take up the task of identifying their contexts and their specific challenges.

X19: I think we need to respect managers for trying to achieve...I think we do need to move away from a traditional notion of a programme with some taught content....People need to be encouraged to select a way that they can think will help with things. So not restricting them to coaching or mentoring...its more about supporting them to become resilient and develop more confidence.....They deserve to have their concerns listened to but when does that ever happen or when is their voice ever heard? And I don't mean team meetings, departmental meetings or training programs. In reality it's about the chance to be able to talk about it. I am talking in terms of facilitated reflection.... My view is the broadest possible about MD.

X20: We know there are lots of MD programs out there and all this kind of business, but for me ultimately, if anything, I'd be looking to help managers assess themselves against a meaningful framework to them. That means something to them.... there are millions of framework out there that managers might want to use....At the end of the day though it should be about a manager who accepts that they are a manager. It's a choice.

X21: If a manager says to me I need MD, my first word is, describe the context in which you work. Tell me the context in which you work. And people struggle...On the one level it's about the day to day job and who they report to. What you're hoping for is the level beyond that and the level beyond that.... Because that turns the whole issue of MD on its head about what it is they are meant to be doing or achieving.

Support at the policy and legislative level for MD is seen as discouraging and is considered to be disconnected with managerial practise. The responsibility lies with organisations realising the need and taking the initiative.

X22: Getting people to define the context for joint service delivery or integrated service in their respective CHP's, there level of understanding is pretty critical to get that level in terms of their own growth and development because I don't think organisations are going to be able to develop them.

X23: I don't see policy and legislation facilitating any kind of MD. It may always stay vague would be a constructive way of putting it. Policy will be policy and I don't think policy makers or legislation makers don't think for a moment what it means for the people who have to manage it. I think they look at their big strategic context and what they think might work. And then they look to people to deliver it....

X24: It's about forward thinking organisations wanting to hear what managers are saying and acknowledging the work that they do. And also it's about encouraging networks for learning. The whole point here is that you can choose your own learning networks...